BRINGING AWARENESS TO FAITH-BASED LEADERS AND HEALTHCARE PROFESSIONALS ON PROVIDING EMOTIONAL AND SPIRITUAL SUPPORT AS CAREGIVERS

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ABSTRACT

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This project was designed to bring awareness to faith-based leaders and healthcare professionals on providing emotional and spiritual support as caregivers. The context of the project was Houston Methodist Hospital in Houston, Texas. The purpose of this project was to explore the importance of leaders and professionals being trained as caregivers. This project study used a qualitative methodology for data analysis. Pretest and posttest questionnaires were given to participants to assess their understanding of caregiving and their own self-care. Information was collected from questionnaire data. The outcome was that training is needed for faith-based leaders and healthcare professionals as caregivers.

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First I would like to give thanks to God for giving me this opportunity. Without You, I can do nothing, but with You all things are possible." Only through the grace of God, who has provided me with strength and perseverance, have I been able to move through this process and celebrate the fruits of my labor.

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unwavering belief in me. And to those of you who have daily lifted me and this project to God in prayer and have continually given me words of encouragement.

DEDICATION

This book is dedicated to my wife, Zandra for your unconditional love and support. To my late brother George Lenard Faust for your encouragement in everything that I set out to accomplish. To my mother, the late Gracie Powell Faust, whose prayers, words of wisdom, and encouragement has helped sustain me through the years. To my earthly father, the late Charlie Faust, Sr., who instilled in me a work ethic to do things in an excellent way; and to my siblings and extended family for your support throughout the years.

ABBREVIATIONS

AARP	American Association of Retired Persons
APC	Association of Professional Chaplains
BCC	Board Certified Chaplain
CPE	Clinical Pastoral Education
HMH	Houston Methodist Hospital
ITC	Interdenominational Theological Center
NFCSP	National Family Caregiver Support Program
NRSV	New Revised Standard Version
PCA	Patient Care Assistant
TMC	Texas Medical Center

INTRODUCTION

This ministerial context is Houston Methodist Hospital (HMH) which is the flagship hospital of Houston Methodist Hospital System. The hospital is situated in the Texas Medical Center (TMC). TMC is internationally recognized as the largest medical center in the world. It boasts the highest density of clinical facilities for patient care, basic science, and translational research, all within a 1.562 square mile radius. The TMC contains 50 nonprofit health care-related institutions, specifically 15 hospitals and two specialty institutions, two medical schools, four nursing schools, and schools of dentistry, public health, pharmacy, and other health-related practices. All 50 institutions are not-for-profit. Some of its member institutions operate facilities outside of the Greater Houston area. The Center is where one of the first and largest air ambulance services was created and where one of the first successful inter-institutional transplant programs was developed. More heart surgeries are performed in TMC than anywhere else in the world.

The immediate context of this minister is the Spiritual Care and Education Department in HMH. It provides an interfaith ministry of pastoral care and support to the patients, family members, visitors, and staff of HMH. As one of the chaplains in this context, he is one who actively represents the institution and promotes the spirit of caring that is manifested in the institution's Vision and Mission. He is an actively contributing member to the inter-disciplinary team approach to patient care that is embraced throughout the hospital. He interacts closely with nurses to inquire about any patients

whom they feel he should visit. He firmly believes that he represent the Spiritual Care and Education Department, not only when he is at work, but everywhere he goes. His attitude, and His behavior represent his department and the theistic values that he is called to promote.

As a chaplain, he is available to patients and families for support related to the impact of hospitalization, illness, grief and other issues. They can meet with the chaplain assigned to their clinical area or unit, have their nurse page the chaplain, or call or fax the Spiritual Care Department to request a visit. A chaplain is available 24 hours a day. The chaplain is also available when patients and families need comfort and support. He is trained to provide comprehensive support in times of crisis, trauma, and grief. He is there to listen when the patient or family member feels vulnerable, confused, lonely, or angry, as well as to provide confidential and non-judgmental spiritual support.

In this ministerial context, he is privileged to be a pastoral caregiver to a multi-cultural, religious and a diverse ethnic population. He strives to respect this diversity. In his ministry as a chaplain, it is important that he be careful in setting appropriate boundaries with the purpose of maintaining the integrity of his pastoral relationship with patients, family and staff. His role is to promote the well-being and interests of the patient and family members, irrespective of their faith tradition, or cultural and ethnic background. Furthermore, it is not his place to impose or promote his culture of faith tradition on anyone. It is his understanding that inclusivity and diversity are foundational values in pastoral services offered to persons.

It is also important that as a chaplain he uphold the ethical principles that underlie his pastoral functioning. Showing respect and affirming the dignity of each individual is

required in his role as a chaplain. This dignity and respect needs to be upheld even when others do not show it to him.

All HMH employees are expected to function at a very high professional level based on the professional standards set by Houston Methodist Hospital. The vision and mission of the institution is promoted and lived out every day. All of the staff is encouraged to live out the "ICARE values;" these are five principles that every department within the hospital memorizes. All departments develop a working commitment which guides their relationships with everyone they meet. These values are Integrity, Compassion, Accountability, Respect and Excellence. Practicing the ICARE values is not an option; it is an essential requirement of every HMH employee. All employees' actions and conduct are measured against these values.

As he reflects upon his ministerial context, there is something about the brokenness of people in this context, especially the care of caregivers that he finds himself identifying with. From his observation, he attempts to address the topic of providing pastoral care and counseling to the caregivers. As one who is a pastoral caregiver in a variety of ways, including that of the more formal and structured ministry of pastoral care and counseling, he acknowledges that he is an adequate counselor concerning many issues. So it is with some fear and trembling, but also with gratitude that he approaches his task. It is his hope that he might be able to offer the caregiver some counsel for their own brokenness and, perhaps, some guidance to help them to avoid the breakdown that sometimes occurs in the lives and ministry of those who are pastoral caregivers.

The focus of the project is to bring awareness to faith-based leaders and healthcare professionals on providing emotional and spiritual support as caregivers.

In Chapter One, the spiritual journey is summarized, including experiences and circumstances that played a role in the selection of the project. The chapter also reviews the ministry context, including the demographics of Houston Methodist Hospital. The chapter communicates precisely to the reader the basis for the project, the presentation of the purpose, research and data collection techniques, and the expected outcome for religious institutions.

Chapter Two explores the scriptural basis relating to the theme. The chapter consists of a complete exploration on how Scripture and Spirituality connect to the project.

Chapter Three identifies a historical foundation for the project that is proposed. It gives the reader an extensive analysis of the historical concepts of caregiving. It takes a look at how the educational and professional developments come together.

Chapter Four communicates the theological concepts of caregiving. Fundamentals are gathered from the theological realms to construct a theological foundation for the praxis and passion of the project.

Chapter Five examines thoughts or theories on the subject that may have emerged over a period of time. The chapter turns to a study of the theory and practice of equipping leaders and professionals to be effective caregivers. It sets out the theories which are central to our understanding of providing care as caregivers.

Chapter Six provides a clear understanding of the research site, the participants, pretest and posttest data, an analysis of that data, and how the project can be used by

other religious organizations and healthcare institutions. The chapter presents a plan of action in executing the study, and uses pretest and posttest, as well as workshop data on equipping caregivers. It also provides the summary, reflection and conclusion of the project. A thoughtful evaluation is presented that outlines the project, including the successes and shortcomings. In addition, the chapter provides recommendations for possible adjustments in future projects, research and training.

CHAPTER ONE

MINISTRY FOCUS

The ministry focus contains the review of the context and the spiritual autobiographical journey along with the general nature of the project. This project is designed to bring awareness to faith-based leaders and healthcare professionals on providing emotional and spiritual support as caregivers. This minister of this ministry focus has always had the desire to better prepare himself in order to equip and train others. It is his contention that effective ministry is born through mutual learning and growth, and serves as an important foundation for clinical training and pastoral care and counseling. His spiritual journey reveals the place where God has been calling him to for a lifetime.

He was born in Gloster, Mississippi to hard working parents. To this union fourteen children were born; seven sons and seven daughters, with him being the ninth child born. When he reflects back over his life analytically, and deductively go back through his past, he could see where God had gotten involved in his life long before he knew anything about God. Reflecting upon his life, a young boy comes to mind. He was reared in Liberty, Mississippi, about twelve miles east of Gloster in an agricultural setting near his paternal grandparents who were sharecroppers.

In spite of the social injustices experienced, economic difficulties and the agricultural situation that he happened to be reared in, his mother would always take him

along with his brothers and sisters to Sunday school and church. It was while attending church that he developed a loving interest in God, and was baptized at the age of thirteen. While in church, he participated in different programs that involved the youth on Thanksgiving, Christmas, Easter, and Mother's Day. He had always wanted to please his mother and make her proud. He recited poems and participated in biblical plays, scripture searching contests, and learned to pray the Lord's Prayer. He also attended Vacation Bible School and the Sunshine Band. Those activities and others helped removed the fear of standing up before audiences, and encouraged him to be the best he could be. These were some needed tools that would help carry him through this journey called the "Christian faith." He could now see how he was predestined and prepared for the journey of faith, and the preaching of the gospel of Jesus Christ.

There were many people who played vital roles in his formative religious experiences and development along with his parents. His mother had a deep impact in his life when it came to caregiving. He recalls one of his first encounters with caregiving was observing his mother being a caregiver to her father and his maternal grandfather who had been paralyzed for some unknown reason. Along with some of his siblings he assisted his mother as a caregiver. He remembers pushing his grandfather around their home in the wheelchair and taking out the slop-jar. His mother was not only a caregiver to her father, but to many people in the neighborhood and around town. Her compassion for helping people rubbed off on his young impressionable mind. He cared for some of the elderly people that lived nearby. He brought the mail from their mailboxes, mowed their lawns, fed the chickens and assisted with many other errands. His caregiving abilities had begun to develop.

It was shortly after enrolling in college that he received a Divine call to prepare himself for the work of the ministry. It was a burning desire within him that could not be denied, which was an indication to him that it was a "calling" by God. He felt a compelling call, sort of like the Apostle Paul, which meant, he too was driven onward by an irresistible and undeniable compulsion to follow God's leadership. Something or some kind of feeling came all over him. It was hard to explain. He had never felt that way before. He felt like running, but he could not. He was crying and did not know what he was crying about. He felt a call from God to do ministry. It reminded him of what Jeremiah described as a "burning fire" (Jeremiah 20:8-9) that could not be quenched. Trying to hold it back made him weary. He interpreted those feelings as a movement of the Holy Spirit—an experience he shared with his mother, who encouraged, but also advised him to be very sure. Having a nervous feeling, somewhere in his mind, he felt led to go into ministry, but he wanted to be certain about it. Not wanting to lead himself, and not wanting to be in the ministry if the called had not come from God, he knew it had to be the unctioning of the Holy Spirit that calls people and anoints them to do God's work.

It was his college experience that started to help shape and nurture his character into becoming the person that God was calling him to be. Away from home for the first time at the age of seventeen, he found himself in situations that required the practice of some godly values that his parents had taught him as a child. It was difficult however, to apply these principles because he realized that he did not have a personal relationship with God. He felt disconnected from God and spiritually incomplete. In retrospect, during those adolescent years, he realized that he had been attending church without having experienced the intimacy with God through Jesus Christ. As he would learn later, having a prayer life and

comprehensive Bible study was also essential in becoming a practitioner of the Christian faith. It was only through some very trying experiences, while matriculating in college that he began to see the Lord God from a different understanding. He had to get to the point of needing and wanting God for himself. Unbeknownst to him, there was a special calling upon his life; God was calling him into the gospel ministry.

Upon graduation from college, he realized that if he was serious about his call, the decision had to be made to sacrifice a few concentrated years in focusing on studying the scriptures, theology, church history, and biblical language, as he allowed the Lord to lead him in his studies.

It was in seminary in Atlanta, Georgia at the Interdenominational Theological Center (ITC) that the faculty and administration created for this young minister a spiritual environment in which critical thinking, investigation, reflection, evaluation, communication, decision-making, and responsible action were fostered. They challenge all students to become involved in the problems that affect the human spirit; to become active on behalf of both the academic community and the community beyond the campus; to develop an appreciation for the disciplines that contribute to theological thinking; to incorporate contemporary technological resources in an ethically responsible fashion; and to maintain continuous development of the intellect, spirit, and skills required for spiritual growth.[1] It was as a seminary student that he decided to concentrate in Christian Education.

It was in his Pastoral Care class that he had an opportunity to further develop in

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[1]Academic Catalog, Interdenominational Theological Center Atlanta, GA 2008-2012, Volume Xxxiii August 2008, "The Educational and Learning Environment," accessed December 14, 2013, http://www.itc.edu/assets/pdf/academics/2008_12_ITC_Catalog_new.pdf.

the area of caregiving. One semester of the class required some field study off campus where he served at a Special Needs Facility. He had twelve residents at the facility that he provided emotional and spiritual support as a pastoral caregiver. The training in his seminary days in Atlanta was very rewarding.

This minister has always had a great interest in developing in teaching, preaching, Christian Education, Pastoral Care and Counseling, but it was during his first pastorate that he began to see the importance of leadership development by way of seminary training. Through his experience from having the privilege to pastor his first church, he has been personally sought, recognized and call forth as a person with leadership potential. As a direct result of what has been done to and for him, he in turn, seeks to recognize and call forth the potential of persons, providing opportunities for their training and growth. It is his understanding that it is impossible to be an effective pastor without properly trained and enthusiastic leadership. Jesus, Himself, chose twelve disciples, then seventy, and dedicated his entire earthly ministry to providing opportunities for training and growth for three and one half years before he ascended back to His Father.

When he looks at who he is in ministry and where he is in ministry, and sees how his educational and professional development come together; he identifies a foundation for the project he is proposing. He sees where providing pastoral care and counseling as a caregiver has played a major part to form his focus in ministry—the need to bring awareness to faith-based leaders and healthcare professionals on providing emotional and spiritual support as caregivers.

It is vital that faith-based leaders and healthcare professionals have an understanding of how to deal with loss and grief as well as emotional issues when it

comes to being a caregiver. Pastors and Faith-based leaders not only need to know how to deliver the word of God, but to provide spiritual and emotional support as caregivers. Before they can do that, they need to be trained. It is his contention that effective ministry is born through mutual learning and growth, and serves as an important foundation for clinical training and pastoral care and counseling. Pastors and faith-based leaders, as well as healthcare professionals play an important role when it comes to providing pastoral care. It is essential that they nurture and develop relationships as caregivers.

If a minister wants to be of real help in his or her contact with people, he or she has to be a professional with special information, special training, and special skills.[2] The minister who cares for people is called to be skillful but not a handyman, knowledgeahle but not an inposter, a professional but not a manipulator. When he or she is able to deny him or herself, to be faithful and to understand the meaning of human suffering, then the person who is cared for will discover that through the hands of those who want to be of help, God shows tender love for them.[3]

When this minister looks at his life in retrospect as a pastoral caregiver, there have been some things that have made major impacts in his life and spiritual pilgrimage. At points in his life and journey, he has experienced the loss of someone and something dear to him. The grief that followed those losses seemed unbearable, but it actually was a healing and teaching process. This experience of loss has helped him to be a better listener when he has offered ministry to persons who experience loss and grief. As a

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[2] Henri J. M. Nouwen, *Creative Ministry* (Garden City, NY: Image Books, 1971), 64.

[3] Henri J. M. Nouwen, 64.

pastoral caregiver he has learned to listen to parishioners, patients, family members and colleagues as they have experience their different stages of grief.

During grief, it is common to have many conflicting feelings. Sorrow, shock, anger, loneliness, sadness, shame, anxiety, and guilt often accompany serious losses. Having so many strong feelings can be very stressful. Yet denying these feelings, and failing to work through the stages of grief, is harder on the body and mind than working through them. When one suggest "looking on the bright side," or other ways of cutting off difficult feelings, the grieving person may feel pressured to hide or deny these emotions. Then it will take longer for healing to take place. Sometimes people get stuck in one of the stages. Their lives can be painful until they move to the stage of acceptance.[4]

In attempts to help the grieving person to understand that while these feelings can be frightening and overwhelming, they are normal reactions to loss. Accepting them as part of the grieving process and allowing themselves to feel what they feel is necessary for healing. He tells them that there is no right or wrong way to grieve — but there are healthy ways to cope with the pain. Grief that is expressed and experienced has a potential for healing.[5] His passion for this work flows out of his own life experiences with grief and death of family and friends.

Reflecting upon his ministerial context, there is something about the brokenness of people in his context, especially the care of caregivers that he finds himself identifying

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[4] Melinda Smith and Jeanne Segal, "Coping with Grief and Loss: Understanding the Grieving Process," HelpGuide.org, last modified February 2015, accessed December 14, 2013, http://www.helpguide.org/articles/grief-loss/coping-with-grief-and-loss.htm.

[5] Melinda Smith and Jeanne Segal, "Coping with Grief and Loss: Understanding the Grieving Process," HelpGuide.org, last modified February 2015, accessed December 14, 2013, http://www.helpguide.org/articles/grief-loss/coping-with-grief-and-loss.htm.

with. From his observation, he attempts to address the topic of providing pastoral care and counseling to the caregivers. As one who is a pastoral caregiver in a variety of ways, including that of the more formal and structured ministry of pastoral care and counseling, he acknowledges that he is an adequate counselor concerning many issues, however he is not always sure he has counsel for his own brokenness. That is to say, he has some idea of what to offer by way of care to others, and others do need this care, but he is not always sure of what to offer himself by way of care. In Henri Nouwen's book The Wounded Healer, he contends that "the minister is called to recognize the sufferings of his time in his own heart and make that recognition the starting point of his service. In other words, the minister must be willing to go beyond his professional role and leave himself open as a fellow human being with the same wounds and suffering."[6]

One of the prevailing traits in ministry is an overwhelming desire to serve people, to help them deepen their relationship with God, and to contribute to the growth of all faith communities. It is this desire to articulate a theology of spiritual care that is integrated with a theory of pastoral practice. One seeks to connect to the ministry of Jesus as He loved, cared, and healed ordinary people, but one's theology has to be large enough to accept the theology of those whom they serve. If one cannot support a patient (family member or staff person) in his or her theology, then they cannot serve as a multi-faith chaplain or caregiver. In order to be an effective multi-faith chaplain, one needs to be secure in their own belief system. They also need to be able to be open to understanding and interpreting the theology of any patient, family member, staff person, or caregiver

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[6] Henri J.M. Nouwen, *The Wounded Healer* (Garden City, NY: Image Books, 1979), xvi.

with whom they come into contact. They have to be open to other people's theology and help them through using their belief system, not their own.[7]

So it is with some fear and trembling, but also with gratitude that this minister of this ministry focus approach his task, in the hope that together he might be able to offer the caregiver some pastoral care and counsel for their own brokenness and, perhaps, some guidance to help them to avoid the breakdown that sometimes occurs in the lives and ministry of those who are pastoral caregivers.

It is unmistakably clear to the experienced pastor that he or she has a major task in counseling others who themselves are carrying major responsibilities as counselors. In other words, he or she is a counselor of counselors. The pastor finds him or herself in a place of spiritual leadership similar to that of men and women of God in earlier days. Moses wore both himself and others out as he tried to be a counselor in all matters, great and small. His father-in-law Jethro wisely advised him to select others and train them to help him in the task. Likewise, at another time Moses became so exhausted himself that he lost patience with the people of Israel and asked God to remove him from this world! God answered his plea by endowing the seventy elders of Israel with the same spirit with which he had blessed Moses. They bore the load with Moses (Exodus 18:13-27). However, Moses became a counselor to them in a special way; he became a counselor of counselors (Numbers 11:14-25). Similarly, the pastor or faith-based leader of today strengthens many counselors in order that they might become a comfort to those for whom they have responsibility as counselors.[8]

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[7] Stephen B. Roberts, *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook* (Woodstock, VT: Skylight Paths, 2012), 5.

[8] Wayne E. Oates, *An Introduction to Pastoral Counseling* (Nashville: Broadman Press 1959), 318.

As the minister of this ministry focus reflects on his spiritual pilgrimage, he sees how and why the Lord brought him into his present context of ministry, and how the hand of God connected his life experience and his context. It happened after he and his wife had worked and served in the Atlanta area for seven years that they decided to move back to Houston, Texas, where they could be closer to Louisiana where his wife's mother lived, whose health had started to decline. He became a caregiver to his wife and assisted her as she cared for her mother. After arriving in Houston, they decided to reunite with the church that had licensed him in the gospel ministry years earlier. It was there that he worked and served four years in a new ministry position as Staff Pastor of Training and Development where he helped to initiate and spearhead different ministries, with one being a counseling ministry. He also had a two year stint at a different church as a Teaching Pastor.

Then the opportunity presented itself for him to pursue his Clinical Pastoral Education (CPE) at the Houston Methodist Hospital (HMH) in the Texas Medical Center (TMC). He left the church circuit at that time, and became a CPE student and a Resident Chaplain. Out of an intense involvement with people in need, and the feedback from peers and supervisors, he developed a new awareness of himself as a person and of the needs of those to whom he ministered to. From theological reflection on specific human situations, he gained a new understanding of ministry. The CPE program served as a part of his preparation for chaplaincy, parish ministry, healthcare ministry, teaching, preaching, and counseling.

The CPE process nurtured him to a deeper spiritual and compassionate capacity, as well as enabled him as a religious leader to strengthen his pastoral effectiveness and

competence in ministry. CPE provided him with opportunities to learn to work with the other professions and to define his unique professional function and pastoral identity in relation to them and in the light of his tradition. CPE also involved participation in personal growth groups that usually were very valuable.[9] Within the interdisciplinary team process of helping persons, he has developed skills in interpersonal and professional relationships. After he completed the CPE process as a Resident Chaplain, he was offered a Staff Chaplain position there at The Methodist Hospital in the Texas Medical Center. Having completed four units of CPE, plus 2,000 hours of work experience and a very challenging application process, he became a Board Certified Chaplain (BCC) with the Association of Professional Chaplains (APC). He then continued to work as a staff chaplain at the now new name change, Houston Methodist Hospital (HMH).

Having served several years in the pastoral ministry of the church and now the chaplaincy ministry, he feels it is not only appropriate, but necessary, to use his pastoral authority in the hospital. He has been blessed to work with patients, family members, and staff in a variety of medical disciplines. He feels like he is respected as a professional and is able to set appropriate boundaries in his interactions with all professions.

Based on his understanding, the real source of his pastoral authority resides in his relationship with God. The authority that he exercises is not of dominion and arbitrary lording over anyone; but as one who represents God. This authority is expressed, not by acting as an isolated individual, but in God, as his faith community and the people all around him see the godly presence in him. As a chaplain, he uses his pastoral authority in a respectful and prudent manner.

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[9] Howard Clinebell, *Basic Types of Pastoral Care & Counseling: Resources for the Ministry of Healing and Growth* (Nashville: Abingdon Press, 2011), 471.

In his pastoral context as a chaplain, he is privileged to be a pastoral caregiver to a multi-cultural, religious and a diverse ethnic population. He strives to respect this diversity. In his ministry as a chaplain, it is important that he be careful in setting appropriate boundaries with the purpose of maintaining the integrity of his pastoral relationship with patients, family and staff. His role as a chaplain is to promote the well-being and interests of the patient/family members, regardless of their faith tradition, or cultural and ethnic background. Furthermore, it is not his place to impose or promote his culture of faith tradition on anyone. It his understanding that inclusivity and diversity are foundational values in pastoral services offered to persons.

In the Spiritual Care and Education Department in the hospital where he works as a chaplain, he provides an interfaith ministry of pastoral care and support to the patients, family members, visitors, and staff of HMH. He actively represents the institution and promotes the spirit of caring that is manifested in the institution's vision and mission. As a chaplain he is an actively contributing member to the inter-disciplinary team approach to patient care that is embraced throughout the hospital. He interacts closely with nurses to inquire about any patients whom they feel he should visit. He firmly believes that he represent the Spiritual Care and Education Department of HMH, not only when he is at work, but everywhere he goes. His attitude, and his behavior represent the department and the theistic values that he is called to promote.

As one of the staff chaplains, he is available to patients and families for support related to the impact of hospitalization, illness, grief and other issues. They can meet with the chaplain assigned to their clinical area or unit, have their nurse page the chaplain, or call or fax the Spiritual Care and Education Department to request a visit.

The chaplain is available when patients and families need comfort and support. He or she is trained to provide comprehensive support in times of crisis, trauma, and grief. The Houston Methodist Hospital Spiritual Care and Education Department provides grief support to patients and their families.[10] The chaplain is also there to listen when the patient or family member feels vulnerable, confused, lonely, or angry, as well as to provide confidential and non-judgmental spiritual support.

The activities on the units which he coordinates at the hospital, especially the promotion of unit devotionals, prayer services, and one-to-one and group ministry with caregivers and staff, and many other activities promote the integration of spiritual values into the life and service of the hospital. He feels that effective ministry is borne through mutual learning and growth, and serves as an important foundation for clinical training and pastoral care and counseling.

As a chaplain, caregiving is his profession. After some years of caring for people's spiritual needs, he has come to realize that it takes tremendous stamina, patience and love to maintain effective pastoral ministry in a caring environment. And that increases the need for a chaplain to have a support system as well as training. For the chaplain, his sense of calling to ministry and the inherent value of people make caring a great passion that makes the balancing of caring for others and caring for himself a bit of a challenge. In fact, all caregivers should strive to recognize the stresses and painful emotions involved in caring and take personal measures for self-care. Doing a very stressful job, he is conscious of the fact that he needs quality time for himself. He has become intentional in taking care of his physical needs through regular exercise and his

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[10] "Houston Methodist Leading Medicine," Houston, TX 2015, accessed December 15, 2013, http://www.houstonmethodist.org/basic.cfm?id=37204.

emotional needs through meditation and relaxation. His spiritual needs are met through prayer, devotion and personal study. He is determined to be more intentional in loving, honoring and valuing himself.

Health care is continuously fluctuating. Change is the order of the day. Learning how to live within this context that is constantly changing requires a certain sense of one's self. It requires an ability to center one's self and invite calm, and sometimes this can only be done in the environment of a space that invites the presence of the sacred.[11]

One can already identify the theme of suffering self-sufficiency that nurtures the need for counseling on the part of both those who seek help and those to whom they turn for it. The pastor must have a continuing "Counselor" at his or her side if they are to he "sufficient for these things." Such is the ministry of the Holy Spirit to the pastor as a counselor of counselors and a caregiver of caregivers. The Holy Spirit is the gift of the Father God upon the specific request of the Son of God for the express purpose that we may have another Counselor who will be with us always. The Holy Spirit moves with us and refusing to allow us to remain as orphans. The Holy Spirit inspires us with new power and sends us into new directions when some great grief has caused us to lose our way and our strength.[12]

The Holy Spirit moves over the face of the deep of our consciousness and brings up into clear awareness those hidden and forgotten recesses of our memory that we may be healed by the remembered teachings of our Lord. The Holy Spirit works in the processes of communication which become hindered and blocked through our sinfully

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[11] Stephen B. Roberts, *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook* (Woodstock, VT: Skylight Paths, 2012), 209.

[12] Wayne E. Oates, *An Introduction to Pastoral Counseling* (Nashville: Broadman Press 1959), 323.

distorted perceptions and enables us to understand each other, "each in his or her own language." The Holy Spirit even moves into the unutterable depths of ourselves and articulates the groanings of our spirits to God when we ourselves have to admit that we cannot pray. The Holy Spirit finally convicts pastors that they, too, are sinners under the righteousness and judgment of God. The Holy Spirit reminds them that they have the ministry of counseling, as every other ministry, as a gift and not an earned right. This gift is held in earthen vessels, in order that the excellency of the power may be of God.[13]

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[13] Wayne E. Oates, *An Introduction to Pastoral Counseling* (Nashville: Broadman Press 1959), 323.

CHAPTER TWO

BIBLICAL FOUNDATIONS

The scripture basis that focuses on supporting the project that is being proposed—the need to bring awareness to faith-based leaders and healthcare professionals on providing emotional and spiritual support as caregivers is found in two passages of scripture: the Old Testament, Isaiah 53:3. "He was despised and rejected by others; a man of suffering and acquainted with infirmity; and as one from whom others hide their faces he was despised and we held him of no account." (NRSV) The New Testament scripture reference is James 5:13-14, "Are any among you suffering? They should pray. Are any cheerful? They should sing songs of praise. Are any among you sick? They should call for the elders of the church and have them pray over them, anointing them with oil in the name of the Lord. The prayer of faith will save the sick, and the Lord will raise them up; and anyone who has committed sins will be forgiven."

At a time when there is concern within the church to draw on its historic resources for use in the transformation of persons, these verses give us a biblical model for the ministry of care to others. The aim of this project is to provide faith-based leaders and healthcare professionals with biblical insights and clear, practical instructions for motivating, organizing, and equipping God's people in how to be effective caregivers in helping people who are ill, bereaved, or who are facing other challenging situations, such as having to care for an aging family member.

In order to have a biblically effective caring ministry to others, this pastoral caregiver must begin by examining and maintaining his own heart's relationship with the Lord. Does he love the Lord first and is he planning to care for someone else because of his love for the Lord and for them? Is he maintaining that close, abiding, personal relationship with Christ that will enable him, by God's grace, to be fruitful in the ministry?

The Old and New Testament scripture basis; Isaiah 53:3 and James 5:13-14, gives us some insights into the ministry of caregiving. These biblical models characterize what a caregiver does and what they look like. Personal encouragement and support can be more easily extended and received among a group of persons who are aware of each one's needs, strengths, and weaknesses. As a pastor and chaplain, he has and will continue to display and encourage other servant leaders to be effective caregivers.

In order to more effectively care for those who have suffered great personal loss we must understand their emotional grief. It is essential that ministers, faith-based leaders and healthcare professionals have an understanding of how to deal with loss and grief as well as emotional issues when it comes to caregiving. Complete understanding is impossible until we have personally experienced it in all of its numbing fullness, however as Godly caregivers, it behooves us to attempt to understand in order that we can intelligently and genuinely care for those in need.

This Biblical Foundation chapter is not so much designed to advise us in actually ministering to the bereaved, but to help us understand some of the elements and expressions of grief. There is some truth in that, until one has personally experienced

serious loss and bereavement, he or she cannot fully understand what another is experiencing. Yet we are called on to have compassion and to provide loving care.

Old Testament

Isaiah 53:3 says, "He was despised and rejected by others; a man of suffering and acquainted with infirmity; and as one from whom others hide their faces he was despised and we held him of no account."

Caregiving can be lonely. People will sometimes reject or forsake loved ones who are ill and have a disability, but God will not forsake them. Nowhere in all the Old Testament is it so plainly and fully prophesied, that Christ ought to suffer, and then to enter into his glory, as in this chapter. Israel badly miscalculated the Servant's importance to them. Isaiah wrote that Israel will confess that she did not value the Servant. She would reject Him because He was considered an ordinary person (Isaiah 53:1-3). The low condition He submitted to and His appearance in the world was not agreeable to the ideas the Jews had formed of the Messiah. It was expected that He should come in pomp; instead of that, He grew before God as a tender shoot, and as a root out of dry ground, that is, from an area where one would not expect a large plant to grow (Isaiah 53:2). In His appearance He did not look like a royal person. The Jewish remnant was not excusing people for rejecting the Servant; it was merely explaining why the nation rejected Him. His whole life was not only humble as to outward condition, but also sorrowful. Being made sin for us, He underwent the sentence sin had exposed us to.

Carnal hearts see nothing in Jesus to desire an interest in Him. Sadly! By many He is still despised, and rejected as to His doctrine and authority![1]

Despised and rejected by others; He was a man of pains and familiar with illness, and as one from whom there is a hiding of face; i.e., humankind instinctively cover their faces that they should not look upon one who is so afflicted. He was despised and we esteemed Him not; "we held Him of no account." He was not only rejected, He was the kind of individual people do not normally want to look at; they were repulsed by Him; they did not think He was important. Yet He was and is the most important Person in the world, for He is the Servant of God.[2]

The picture thus far represents one so fearfully stricken of God that people could not endure the sight of Him because of their uprising pity, or because they feared some contamination, or He was contagious. When, however, they had come thus far in contemplation and in thought upon the situation, there arose within them a new suggestion. They had felt, as did Job's friends as they looked at him, convinced in their minds that God had so terribly afflicted him because of sins of which he had been guilty. They were brought to see the truth. So in this case the people of Israel began to repent of the judgments already formed and now had adopted the view that the suffering Servant was really innocent, that the punishment which He was enduring was not personal but

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[1]John F. Walvoord and Roy B. Zuck, *The Bible Knowledge Commentary* (USA: Victor Books, 1983), 1107.

[2] John F. Walvoord and Roy B. Zuck, 1107.

national. He was suffering for the sins of others, the sins of His own people, and for these He was suffering vicariously.[3]

"He is despised" requires no explanation and it needs no comment to show that it was fulfilled. The Redeemer was eminently the object of contempt and scorn by the Pharisees, Sadducees, and Romans. In Jesus' life on earth and in His death; He is still looked upon the same today with contempt. Nothing is a more striking fulfillment of this than the conduct of the Jews today. The very name of Jesus of Nazareth excites contempt and they join with their fathers who rejected Him in heaping on Him every term indicative of scorn.[4]

In agreement with the rendering of the Septuagint, "A man in affliction, and knowing to bear languor, or disease;" but the word means disease; it is only figurative of severe sufferings both of body and soul. Hengstenberg, Koppe, and Ammon, suppose that the figure is taken from the leprosy, which was one of the most severe of all diseases, but was looked upon as a divine judgment. They believe that many of the expressions which follow may be explained with reference to this (compare Hebrews 4:15). The idea is that He was familiar with sorrow and calamity. It does not mean, as it seems, that Jesus was to be Himself sick and diseased; but that He was to be subject to various kinds of calamity, and that it was to be a characteristic of His life that He was familiar with it. He was intimate with it. He knew it personally; He knew it in others. He lived in the midst of scenes of sorrow, and He became intimately acquainted with its various forms and with its evils. There is no evidence that the Redeemer was Himself sick at any time, which is

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[3] Frederick Carl Eiselen, ed., Edwin Lewis, ed., and David G. Downey, ed., *The Abingdon Bible Commentary* (USA: Abingdon Press, 1929), 662.

[4] Frederick Carl Eiselen, ed., Edwin Lewis, ed., and David G. Downey, ed., 662.

remarkable, but there is evidence in abundance that He was familiar with all kinds of sorrow, and that His own life was a life of grief.[5]

"He is despised;" rather, was despised. People's disrespect was shown, partly in the little attention which they paid to His teaching, partly in their treatment of Him on the night and day before the Crucifixion. "Rejected of others;" rather, perhaps, forsaken of others; "one from whom others held themselves aloof." Our Lord had at no time more than a "little flock" attached to Him. Of these, after a time, "many went back, and walked no more with Him." Some, who believed on Him, would only come to Him by night. All the rulers and great people distance themselves from Him. At the end, even His apostles "forsook Him, and fled." A Man of sorrows; the word "sorrows" means also pains of any kind. But the beautiful rendering of our version may well stand, since there are many places where the word used certainly means "sorrow" and nothing else. The "sorrows" of Jesus appear on every page of the Gospels. "Acquainted with grief" literally means with sickness. We hid as it were our faces from Him. Some presume the hiding of God's face to be intentional, however the context, which describes the treatment of the Servant by humankind, makes the meaning given in our version far preferable. People turned their faces from Him when they met Him, would not see Him, and would not recognize Him. Despised; a repetition very characteristic of Isaiah.[6]

"He is despised and rejected," "forsaken of humankind." Literally, He who ceases from others, that is, is no longer regarded as a man. "Rejected of others" is a phrase full of meaning, and in three words states the whole history of humankind in regard to their

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[5] Jamieson-Fausset-Brown Bible Commentary, BibleHub.com, accessed April16, 2014, http://biblehub.com/isaiah/53-3.htm.

[6] Albert Barnes' Notes on the Bible, BibleHub.com, accessed April 16, 2014, http://biblehub.com/commentaries/isaiah/53-3.htm.

treatment of the Redeemer. The name "The Rejected of Humankind," will express all the melancholy history, rejected by the Jews, by the rich, the great and the learned; by the mass of people of every status, and age, and rank. No prophecy was ever more strikingly fulfilled; none could condense more significance into few words. In regard to the exact sense of the phrase, interpreters have varied. Jerome (the Vulgate) renders it, "The last of humankind;" that is, the most abject and contemptible of humankind. The Septuagint, "His appearance is dishonored and defective more than the sons of others." The Chaldee renders it, "He is indeed despised, but He shall take away the glory of all kings; they are infirm and sad, as if exposed to all calamities and sorrows." Some render it, "Most abject of humankind," and they refer to Job 19:14, where the same word is used to denote those friends who forsake the unfortunate.[7]

There was a ceasing, or a withdrawing of that which usually pertains to humankind, and which belongs to them. And the thought probably is, that Jesus was not only "despised," but that there was an advance on that; there was a ceasing to treat Him as if He had human feelings, and was in any way entitled to human fellowship and sympathy. It does not refer, therefore, so much to the active means employed to reject Him, as to the fact that He was regarded as cut off from humankind and the idea is not essentially different from this, that He was the most abject and vile of mortals in the estimation of others; so vile as not to be deemed worthy of the treatment due to the

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[7] Albert Barnes' Notes on Isaiah 53:3, BibleHub.com, accessed April 16, 2014, http://www.godvine.com/bible/isaiah/53-3.htm.

lowest of individuals. This idea has been substantially expressed in the Syriac translation.[8]

"A man of sorrows;" that is, whose distinguishing characteristic was sorrows; what a beautiful expression! A man who was so sad and sorrowful; whose life was so full of sufferings, that it might be said that that was the characteristic of the man. A similar phraseology occurs in Proverbs 29:1, 'He that being often reproved,' 'a man of reproofs;' 'A man of chastisements,' that is, a man who is often chastised. Compare Daniel 10:11 . 'O Daniel, a man greatly beloved,' 'A man of desires;' that is, a man greatly desired. Here, the expression means that his life was characterized by sorrows. How remarkably this was fulfilled in the life of the Redeemer, it is not necessary to attempt to show.

"Acquainted with grief," acquainted with; familiar by constant contact with. The word rendered 'grief' means usually sickness, disease; but it also means anxiety, affliction; and then any evil or calamity. Grief literally, "disease;" figuratively for all kinds of calamity; leprosy especially represented this, being understood as a direct judgment from God. It is remarkable Jesus is not mentioned as having ever suffered under sickness. Many of the old interpreters explain it as meaning: that He was known or distinguished by disease; that is, He was affected by it in a remarkable manner.[9]

We are not "acquainted with grief" in the same way our Lord was acquaiuted with it. He feels that we endure it and live through it, but we do not become intimate with it. At the beginning of our lives we do not bring ourselves to the point of dealing with the reality of sin. We look at life through the eyes of reason and say that if a person will

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[8] Jamieson-Fausset-Brown Bible Commentary, BibleHub.com, accessed April16, 2014, http://www.biblestudytools.com/commentaries/jamieson-fausset-brown/isaiah/isaiah-53.html8.

[9] Jamieson-Fausset-Brown Bible Commentary, BibleHub.com, accessed April16, 2014, http://www.biblestudytools.com/commentaries/jamieson-fausset-brown/isaiah/isaiah-53.html8.

control his or her instincts, and educate him or herself, he or she can produce a life that will slowly evolve into the life of God. But as we continue on through life, we find the presence of something which we have not yet taken into account, namely sin—and it upsets all of our thinking and our plans. Sin has made the foundation of our thinking unpredictable, uncontrollable, and irrational. We have to recognize that sin is a fact of life, not just a shortcoming. We must mentally bring ourselves to terms with this fact of sin. It is the only explanation why Jesus Christ came to earth, and it is the explanation of grief and sorrow of life.[10]

Jesus Christ never committed one act of sin but suffered more than any for sin. How? "For our sake the Lord made Him to be sin who knew no sin, so that in Him we might become the righteousness of God," 2 Corinthians 5:21. He became the Sacrifice for our sins. "He was wounded for our transgressions, crushed for our iniquities; upon Him was the punishment that made us whole, and by His bruises we are healed. All we like sheep have gone astray; we have all turned to our own way, and the LORD has laid on him the iniquity of us all," Isaiah 53:5-6. Yet, it pleased the Lord to crush Him with pain; to put Him to grief. When you make his life an offering for sin, he shall see his offspring and shall prolong His days; through Him the will of the LORD shall prosper. Out of His anguish He shall see light; He shall find satisfaction through His knowledge. The righteous One, My Servant, shall make many righteous, and He shall bear their iniquities," Isaiah 53:10-11. What an amazing God. What unconditional love. The Sovereign God was pleased to bruise Him. He became separated for our sins. Sin

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[10] Oswald Chambers, *My Utmost For His Highest*, ed. James Reimann (Grand Rapids, MI: Discovery House, 1992), June 23.

separates from God. "He was oppressed, and he was afflicted, yet he did not open his mouth; like a lamb that is led to the slaughter, and like a sheep that before its shearers is silent, so he did not open his mouth," Isaiah 53:7. God chose not to answer the prayer of Jesus in the Garden of Gethsemane. Jesus said, "Not my will but yours be done," Luke 22:42. Perhaps the greatest sorrow for the man of sorrows is found in this question from the cross asked hy Jesus "My God, my God, why have you forsaken me?" Matthew 27:46. God turned God's back on Jesus so God would not have to turn God's back on us.

Furthermore, we hid as it were our faces from Him. Rather, as one who causes people to hide their faces from Him (in aversion). When the prophet said "We," he was identifying Himself with the Jews. He was hiding His face as a person covers his or her face in disgust. The idea seems to be, that he was as one from whom people hide their faces, or turn away. This might either arise from a sight of his sufferings, as being so offensive that they would turn away in pain as in the case of a leper; or it might be, that he was so much an object of contempt, and so unlike what they expected, that they would hide their faces and turn away in scorn. This latter I suppose to be the meaning; and that the idea is, that he was so unlike what they had expected that they hid their faces in affected or real contempt.[11]

The contempt they put upon the person of Christ because of the meanness of His appearance. This seems to come in as a reason why they rejected His doctrine, because they were prejudiced against His person. When He was on earth many that heard Him preach, and could not but approve of what they heard, would not give it any regard or entertainment, because it came from one that made so small a figure and had no external

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[11] Jamieson-Fausset-Brown Bible Commentary, BibleHub.com, accessed April16, 2014, http://www.biblestudytools.com/commentaries/jamieson-fausset-brown/isaiah/isaiah-53.html8.

advantages to recommend Him. Note here, the low condition He submitted to, and how He abased and emptied Himself. The entry He made into the world, and the character He wore in it, was no way agreeable to the ideas which the Jews had formed of the Messiah and their expectations concerning Him, but quite the reverse.

(1) It was expected that His extraction would be very great and noble. He was to be the Son of David, of a family that had a name like to the names of the great persons that were in the earth. But He sprang out of this royal and illustrious family when it was reduced and sunk, and Joseph, that son of David, who was His supposed father, was but a poor carpenter; perhaps a ship-carpenter, for most of His relations was with fishermen. This is meant by His being "a root out of a dry ground," His being born of a mean and despicable family, in the north, in Galilee. A family out of which like a dry and desert ground, nothing green, nothing great, was expected. In a country of such small repute that it was thought no good thing could come out of it. His mother, being a virgin, was as dry ground, yet from her He sprang who is not only fruit, but root. The seed on the stony ground had no root; but, though Christ grew out of a dry ground, He is both the root and the offspring of David, the root of the good olive.

(2) It was expected that He should make a public entry, and come in pomp and with observation; but, instead of that, He grew up before God, not before people. God's eye was upon Him, but humankind regarded Him not: "He grew up as a tender plant," silently and without any noise, as the corn, that tender plant, grows up, we know not how. Christ rose as a tender plant, which, one would have thought, might easily be crushed, or might be nipped in one frosty night. The gospel of Christ, in its beginning, was as a grain of mustard seed, so inconsiderable did it seem.

(3) It was expected that He should have some uncommon beauty in his face and person, which should charm the eye, attract the heart, and raise the expectations of everyone that saw Him. But there was nothing of this kind in Him; not that He was in the least deformed or distorted, but "He had no form or majesty," nothing extraordinary, which one might have thought to meet with in the countenance of an incarnate deity. Those who saw Him could not see that there was any beauty in Him that they should desire Him, nothing in Him more than in another beloved. Moses, when he was born, was exceedingly fair, to such a degree that it was looked upon as a happy presage. David, when he was anointed, was of a beautiful countenance, and goodly to look to. But our Lord Jesus had nothing of that to recommend Him. Or it may refer not so much to His person as to the manner of His appearing in the world, which had nothing in it of sensible glory. His gospel is preached, not with the enticing words of humanity's wisdom, but with all plainness, agreeable to the subject.

(4) It was expected that He should live a pleasant life, and have a full enjoyment of all the delights of the sons and daughters of humankind, which would have invited all sorts to Him; but, on the contrary, He was "a Man of sorrows and acquainted with grief." It was not only His last scene that was tragic, but His whole life was so, not only mean, but miserable,—but one continued chain of labor, sorrow, and consuming pain.—Sir R. Blackmore. Thus, being made sin for us, He underwent the sentence sin had subjected us to, that we should eat in sorrow all the days of our life, and thereby relaxed much of the rigor and extremity of the sentence as to us. His condition was, upon many accounts, sorrowful. He was unsettled and had nowhere to lay His head, lived upon alms, was opposed and threatened, and endured the contradiction of sinners against Himself. His

spirit was tender, and He admitted the impressions of sorrow. We never read that He laughed, but often that He wept.[12] Grief was His intimate acquaintance; for He acquainted himself with the grievances of others, and sympathized with them, and He never set His own at a distance; for in His transfiguration he talked of his own decease, and in His triumph He wept over Jerusalem.[13]

Isaiah goes on to say, "And we held Him of no account;" that is, we esteemed Him as nothing; we set no value on Him. In order to give greater energy to a declaration, the Hebrews frequently express a thing positively and then negatively. The prophet Isaiah had said that they held Him in positive contempt; he says that they did not regard Him as worthy of their notice. He speaks in the name of his nation as one of the Jewish people. "We, the Jews, the nation to whom He was sent, did not esteem Him as the Messiah, or as worthy of our affection or regard."[14]

Let us look to Him and mourn. The low opinion that people had of Him, upon this account; being generally apt to judge of persons and things by the sight of the eye, and according to outward appearance, they saw no beauty in Him that they should desire Him. There was a great deal of true beauty in Him, the beauty of holiness and the beauty of goodness, enough to render Him the desire of all nations; but the far greater part of those among whom He lived, and conversed, saw none of this beauty, for it was spiritually

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[12] John Gill's Exposition of the Bible, BibleStudyTools.com, accessed April 16, 2014, http://www.biblestudytools.com/commentaries/gills-exposition-of-the-bible/isaiah-53-3.html.

[13] Luke 9:31, Luke 19:41.

[14] Albert Barnes' Notes on Isaiah 53:3, GodVine.com, accessed April 16, 2014, http://www.godvine.com/bible/isaiah/53-3.htm.

discerned. Carnal hearts see no excellency in the Lord Jesus, nothing that should persuade them to desire acquaintance with Him or interest in Him.

Based on what Isaiah said, "And we held Him of no account;" an excellent biblical example of *caring*, is when Jesus tells the parable of the Good Samaritan. "A lawyer stood up to test Jesus." "Teacher," he said, "what must I do to inherit eternal life?" He said to him, "What is written in the law? What do you read there?" He answered, "You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbor as yourself." And he said to him, "You have given the right answer; do this, and you will live." But wanting to justify himself, he asked Jesus, "And who is my neighbor?" Jesus replied, "A man was going down from Jerusalem to Jericho, and fell into the hands of robbers, who stripped him, beat him, and went away, leaving him half dead. Now by chance a priest was going down that road; and when he saw him, he passed by on the other side. So likewise a Levite, when he came to the place and saw him, passed by on the other side. But a Samaritan while traveling came near him; and when he saw him, he was moved with pity. He went to him and bandaged his wounds, having poured oil and wine on them. Then he put him on his own animal, brought him to an inn, and took care of him. The next day he took out two denarii, gave them to the innkeeper, and said, 'Take care of him; and when I come back, I will repay you whatever more you spend.' Which of these three, do you think, was a neighbor to the man who fell into the hands of the robbers?" He said, "The one who showed him mercy." Jesus said to him, "Go and do likewise."[15]

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[15] Luke 10:25-37.

What the Samaritan did helps this writer to better understand what it means to "show mercy" (Luke 10:37), and it also illustrates the ministry of Jesus Christ. The Samaritan identified with the stranger and had compassion on him. There was no logical reason why he should rearrange his plans and spend his money just to help an "enemy" in need, but mercy does not need reasons. One may read this passage and think only of the high cost of caring, but it is far more costly not to care. The priest and the Levite lost far more by their neglect than the Samaritan did by his concern. They lost the opportunity to become better persons and good stewards of what God had given them. They could have been a good influence in a bad world, but they chose to be bad influence. The Samaritan's one deed of mercy has inspired sacrificial ministry all over the world. What Jesus said to the lawyer, He says to humankind "Go and keep on doing it likewise."

Going back to what Isaiah said, "And we held Him of no account;" There was nothing attractive in the physical appearance of this Servant. Israel miscalculated the Servant's importance—they considered Him as an ordinary man. But even though Jesus did not attract a large following based on His physical appearance, He brought salvation and healing. Most people miscalculate the importance of Jesus' life and work. They need faithful Christians to point out His extraordinary nature. The "Man of sorrows" was rejected by those around Him, and He is still rejected by many today. Some reject Him by standing against Him. Others ignore Him and his great gift of forgiveness.

How could an Old Testament person understand the idea of Christ dying for our sins—actually bearing the punishment that we deserved? The sacrifices suggested this idea, but it is one thing to kill a lamb, and something quite different to think of God's chosen servant as that Lamb. But God was pulling aside the curtain of time to let the

people of Isaiah's day look ahead to the suffering of the future Messiah and the resulting forgiveness made available to all humankind.

The real value of a person is inside, not outside. Although a person's body may be diseased or deformed, the person made inside is no less valuable to God. No person is too disgusting for His touch in a sense; we are all diseased, because we have all been deformed by the ugliness of sin (Romans 3:23). But God, by sending Jesus, has touched us, giving us the opportunity to be healed. When one feel repulsed by others, stop and remember how God feels about that person—and about us.

We can all be thankful for One who has gone before us in this and has experienced the ultimate in suffering and grief and He has done so on our behalf. As we read and meditate on the truths of Isaiah 53 speaking of the Messiah, Jesus, who would suffer for the sins of all people. Such a prophecy is astounding! Who would believe that God would choose to save the world through a humble, suffering servant rather than a glorious king? The idea is contrary to human pride and worldly ways. But God often works in ways we do not expect. The Messiah's strength is shown by humility, suffering, and mercy.

As the ultimate Caregiver; not only does the Messiah understand what we go through, but also has dealt with the ultimate cause of all of our suffering and losses through His cross and grave, and that one day He will free us from all such traumas forever.

New Testament

The New Testament scripture basis that is used to support the project that is proposed is found in James 5:13-15. "Are any among you suffering? They should pray. Are any cheerful? They should sing songs of praise. Are any among you sick? They should call for the elders of the church and have them pray over them, anointing them with oil in the name of the Lord. The prayer of faith will save the sick, and the Lord will raise them up; and anyone who has committed sins will be forgiven."

Since pastors and church leaders play an important role in providing caregivers with pastoral care. It is essential that pastors, church, and faith-based leaders should have a prayer life, and that caregiving should be accompanied with prayer. It is vitally important that faith-based leaders as well as healthcare professionals nurture and develop their prayer lives when dealing with the sick, as well as providing emotional and spiritual support to caregivers.

A fitting climax to James is his emphasis on prayer. The greatest assistance any believer can offer another is faithful prayer. Prayer is clear evidence of care. Prayer is the "hotline" to the Lord who can provide for any need no matter how complex or impossible it may seem. To share in prayer, a believer must have sensitivity to someone's needs, engage in diligent supplication for those needs, and recognize the significance of those needs.[16] Perhaps the two greatest weaknesses in the average church today are the areas of prayer and praise. The reason for these weaknesses may be traced to insensitivity. There is much need for prayer and much cause to praise.

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[16] John F. Walvoord and Roy B. Zuck, *The Bible Knowledge Commentary* (USA: Victor Books, 1983), 834.

James raised several questions to stress these points. "Are any among you suffering?" James means that there is no time in which God does not invite us to Godself. For afflictions ought to encourage us to pray; wealth supplies us with an occasion to praise God. But such is the perverseness of people that they cannot rejoice without forgetting God and that when suffering they are discouraged and driven to despair. We ought, then, to keep within due bounds, so that the joy, which usually makes us to forget God, may prompt us to set forth the goodness of God, and that our sorrow may teach us to pray. For God has set the singing of psalms in opposition to profane and unbridled joy; and thus they express their joys who are led, as they ought to be, by affluence to God.[17]

James indicated that everybody does not go through troubles at the same time. "Are any cheerful? Let them sing songs of praise." God balances our lives and gives us hours of suffering and days of singing. The mature Christian knows how to sing while he or she is suffering. (Anybody can sing after the trouble has passed.) God is able to give "songs in the night" (Job 35:10). God did this for Paul and Silas when they were suffering in that Philippian jail. "At midnight Paul and Silas prayed, and sang praises unto God" (Acts 16:25).

James asked a third question and then answered it completely. "Are any among you sick?" These verses have been greatly misinterpreted. Some seem to teach from this passage of scripture that complete physical health is always just a prayer away. Others have found in this passage justification for "extreme unction" (a practice begun in the eighth century). Still others have tried to relate the process outlined by James to the

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[17] J. Calvin and J. Owen, *Commentaries on the Catholic Epistles* (Bellingham, WA: Logos Bible Software, 2010), 354-357.

modern practice of invoking God ("pray over them") and using medicine ("anoint them with oil")—prayer plus a physician.[18]

The center of the problem lies in just what James meant when he referred to the "sick." Actually there is no reason to consider "sick" as referring solely to physical illness. Although it is used in the Gospels for physical maladies, it is generally used in Acts and the Epistles to refer to a weak faith or a weak conscience.[19]

James was not referring to the bedridden, the diseased, or the ill. Instead he wrote to those who had grown weary, who had become weak both morally and spiritually in the midst of suffering. These are the ones who should call for the help of the elders of the church. The early church leaders were instructed to "encourage the timid" and "help the weak."[20]

James urged believers to use prayer in all the seasons of life. In times of affliction Christians are to pray to God for help and strength (5:13a). In times of blessing believers are to praise God instead of congratulating themselves (5:13b). In instances of critical sickness the sick person was to summon the leaders of the church for prayer. Prayer for the sick could result in either physical healing or spiritual blessing (5:14–15). In times of sin and struggle mutual intercession could promote spiritual victory (5:16). Elijah prayed

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[18] "Supplication for Needs," Commerce Church of Christ, accessed October 21, 2015, https://commercechurchofchrist.files.wordpress.com/2015/07/announcement-sheet-2015-7-12.pdf.

[19] "Supplication for Needs," Commerce Church of Christ, accessed October 21, 2015 https://commercechurchofchrist.files.wordpress.com/2015/07/announcement-sheet-2015-7-12.pdf.

[20] "Supplication for Needs," Commerce Church of Christ, accessed October 21, 2015, https://commercechurchofchrist.files.wordpress.com/2015/07/announcement-sheet-2015-7-12.pdf

with such force that God withheld rain from the earth for three and a half years and gave it again at his request (5:17–18).[21]

James said that the elders should "pray over them and anoint them with oil." It is significant that the word "anoint" is "aleipsantes" ("rub with oil") not "chrio" ("ceremonially anoint"). The former is the "mundane" word and the latter is "the sacred and religious word." "Therefore James is not suggesting a ceremonial or ritual anoiuting as a means of divine healing; instead, he is referring to the common practice of using oil as a means of bestowing honor, refreshment, and grooming." Thus James' point is that the "weak" and "weary" would be refreshed, encouraged, and uplifted by the elders who rubbed oil on the despondent heads, and prayed for them.[22]

For the fallen, discouraged, distressed weary believer, restoration is assured and the elders' prayer offered in faith will make the sick person (literally, "weary one") well ("will restore them from discouragement and spiritual defeat"), "and the Lord will raise them up."[23]

That the restoration is spiritual, not physical, is further clarified by the assurance, "if they have sinned, they will be forgiven." Many physically ill Christians have called on elders to pray for them and anoint them with oil, but a large percentage of them have

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[21] D. S. Dockery, T. C. Butler, C. L. Church, L. L. Scott, M. A. Ellis Smith, and J. E. White, *Holman Bible Publishers* (Nashville, TN: Holman Bible Publishers, 1992), 761.

[22] Chronicles of Ron, "I Command #Fail – How Not To Heal," accessed October 21, 2015, https://ronljacobs.wordpress.com/2013/11/07/i-command-fail-how-not-to-heal/.

[23] Chronicles of Ron, "I Command #Fail – How Not To Heal," accessed October 21, 2015, https://ronljacobs.wordpress.com/2013/11/07/i-command-fail-how-not-to-heal/.

remained sick. This fact suggests that the passage may have been mistakenly understood as physical restoration rather than spiritual restoration.[24]

As the gift of healing as yet continued, James directs the sick to have an alternative to that remedy. It is, indeed, certain that they were not all healed; but the Lord granted this favor as often and as far as the Lord knew it would be beneficial; nor is it probable that the oil was indiscriminately applied, but only when there was some hope of restoration. For, together with the power there was given also discretion to the ministers; for fear that they should by abuse profane the symbol. The design of James was no other than to commend the grace of God which the faithful might then enjoy, in case the benefit of it should be lost through contempt or neglect.[25] James say, "They should call for the elders of the church and have them pray over them, anointing them with oil in the name of the Lord. The prayer of faith will save the sick, and the Lord will raise them up; and anyone who has committed sins will be forgiven."

Let us take a look at the passage. "Are any among you sick? They should call for the elders of the church." We would use the word "pastors" of the church. Three words refer to the office of a pastor. One of the words is translated as "elder," referring to the honor of the office. Another means "bishop," which refers to the assignment, the responsibility of the office. And the third one means "shepherd," which refers to their pastoral care of the congregation. But all three words are used interchangeably of the same office. They refer to the same person, whether they are called an elder, a bishop or a

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[24] Chronicles of Ron, "I Command #Fail – How Not To Heal," accessed October 21, 2015, https://ronljacobs.wordpress.com/2013/11/07/i-command-fail-how-not-to-heal/.

[25] J. Calvin and J. Owen, *Commentaries on the Catholic Epistles* (Bellingham, WA: Logos Bible Software, 2010), 354-375.

pastor, or a shepherd; it is all the same person in the New Testament. So if one is sick, let them call for the "pastors" of the church and let them pray over them, "anointing them with oil in the name of the Lord: and the prayer of faith will save the sick."[26]

Let it be included here generally all those who presided over the Church; for pastors were not alone called presbyters or elders, but also those who were chosen from the people to be as it were censors to protect discipline. For every Church had as it were, its own governing body, chosen from leaders of weight and proven integrity. But as it was customary to choose especially those who were endowed with gifts more than ordinary, he ordered them to send for the elders, as being those in whom the power and grace of the Holy Spirit more particularly appeared. Let them pray over them. This custom of praying over one was intended to shew, that they stood as it were before God; for when we come as it were to the very scene itself, we utter prayers with more feeling; and not only Elisha and Paul, but Christ himself, aroused the fervor of prayer and commended the grace of God by thus praying over individuals. (2 Kings 4:32; Acts 20:10; John 11:41).[27]

We have the privilege of joining with our brothers to bring both illness and sin to God for healing. James insisted that we not underestimate the importance of prayer. "The prayer of a righteous man is powerful and effective" (James 5:16). Note that many see the promise of healing here as linked with confession, and the sickness as a divine judgment.

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[26] W.A. Criswell, *Expository Sermons on the Epistle of James* (Grand Rapid, MI: Zondervan, 1975), 108.

[27] J. Calvin and J. Owen, *Commentaries on the Catholic Epistles* (Bellingham, WA: Logos Bible Software, 2010), 354–357.

In any case, we are to bring all our needs to Jesus, confident that He does hear and answer prayer.[28]

James says, "Prayer will heal them and the Lord will raise them up and if any have committed sins they will be forgiven." It is believed that James is saying that if the illness is caused by their own wrongdoing or if it is not caused by a person's wrong doing, their sins will be forgiven. In the praying and anointing, the person is not only healed in their physical body, but they are also healed in their heart and soul. They are forgiven.[29]

In verse 14, in the case of serious illness, James counsels, the elders of the church should be called. Their prayers were to be accompanied by anointing with oil in the name of the Lord. In some cases oil may have therapeutic value, but in most cases its use is best understood as an aid to faith. James 5:14, in particular, speak to leaders. Prayer is a significant function that leaders are to perform. Consider what James calls leaders to do: (1) Identify: Leaders are to identify the problems, then identify with the problems. They are to come to the aid of those in need, whether they suffer from sickness, suffering, or sin. (2) Intercede: Leaders are to pray for those in need. This involves anointing the person with oil, laying hands on him or her, and praying for restoration. (3) Intervene: Leaders are to throw themselves in the direction of their prayers. In addition to prayer, they should do anything they can to aid in the restoration for which they so earnestly pray.

In verse 15, it is clear from this verse that it is not the oil that heals the sick person, but rather the Lord will raise them up in answer to the prayer of faith. This is not to

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[28] L. Richards and L. O. Richards, *The Teacher's Commentary* (Wheaton, IL: Victor Books, 1987), 1024-1025.

[29] W.A. Criswell, *Expository Sermons on the Epistle of James* (Grand Rapids, MI: Zondervan, 1975), 108.

suggest that God always answers believing prayer. All prayer, including prayer for healing, is subject to the will of God. God does not always answer our prayers the way we want God to. Sometimes, certainly not always, sickness is the result of personal sin; sometimes we cause our own illness.

There is a natural occurring of disease caused by either sinful habits or sinful lifestyles. Cirrhosis of the liver is often caused by alcohol consumption, whereas hardening of the arteries results from gluttony. Smoking can cause lung and vascular problems leading to sickness and death. There are also sexually transmitted diseases such as AIDS and different forms of venereal diseases that are the results of sinful lifestyles. To be considered is a woman who has been raped by a man and gets a disease from him, but is not guilty of a sin or particular sinful lifestyle. Also to be considered, there are many sickly, dying saints who have not been guilty of a particular sin or a sinful lifestyle. This study is not to judge every sickness to determine for what purpose it is. Only God can ultimately do that. Perhaps this is what is meant by if they have committed sins. In any event, the sick person is assured of forgiveness.

It is not the anointing of the oil that heals, but the praying. The Greek word translated "anointing" is a medicinal term. It could be translated to mean "massaging." This may be an indication that James suggests using available means for healing along with asking the Lord for His divine touch. God can heal with or without means, in each case it is God who does the healing. But what is "the prayer of faith" that heals the sick? The answer is in 1 John 5:14-15; "And this is the boldness we have in him, that if we ask anything according to his will, he hears us. And if we know that he hears us in whatever we ask, we know that we have obtained the requests made of him." The "prayer of faith"

is a prayer offered when one knows the will of God. The elders, be it male or female, would seek the mind of God in the matter, and then pray according to God's will. Keep in mind that it is not one individual who is praying: it is the body of elders—spiritual leaders of God—who seek God's will and pray. James does not instruct the believer to send for a faith healer. The matter is in the hands of the leaders of the local church.[30]

Let it also be noted that the apostle says they should call for the elders of the church; that is, they should send for them. They should not wait for them to hear of their sickness, as they might happen to, but they should cause them to be informed of it, and give them an opportunity of visiting them and praying with them. The fact that the sick person calls is an expression of faith, which is one condition for effective prayer (James 1:6-7). The fact that the elders are the ones called is an expression of submission and unity in the church, which are additional conditions for powerful praying. There is no indication of specialized spiritual gifts here (as in Paul's letters). James envisions a spiritual power available to the church and exercised through the elders. This is not at all to diminish the importance of personal prayer by each Christian. It is to affirm the value of agreement by the church, for Jesus promised that agreement among Christians would unleash power for answered prayer (Matthew 18:19-20; John 15:7-17).[31]

Nothing is more common than for persons, even members of the church. to be sick a long time, and to presume that their pastor must know all about it; and then they wonder why the pastor does not come to see them, and think hard of them because they

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[30] "Unlocking the Bible," Barrington, IL 60011, accessed October 25, 2015, http://www.unlockingthebible.org/what-does-it-mean-to-pray-with-faith/.

[31] "Bible Gateway," The IVP New Testament Commentary Series, accessed October 25, 2015, https://www.biblegateway.com/resources/ivp-nt/How-Pray.

do not. A pastor cannot be expected to know everything; nor can it be presumed that the pastor knows when persons are sick, any more than they can know anything else, unless they are apprised of it. Many hard thoughts and many suspicions of neglect would be avoided, if, when persons are sick, they would in some way inform their pastor of it. It should always be presumed of a minister of the gospel that they are ready to visit the sick. But how can one go unless one is in some way made aware of the illness of those who need their counsel and their prayers? The sick send for their family physician; why should they presume that their pastor will know of their illness any more than that their physician will?[32]

And let them pray over them, with them, and for them. A person who is sick is often little capable of praying themselves, and it is a privilege to have someone to lead their thoughts in devotion. Besides, the prayer of a good person is powerful and effective in restoring them to health, James 5:15. Prayer is always one important means of obtaining divine favor and there is no place where it is more appropriate than at the bedside. There relief from pain may be granted; the mind may be calm and submissive, that the medicines employed may be blessed to a restoration to health, and past sins may be forgiven. James 5:15 further states that they who are sick may be sanctified by their trials, that they may be restored to health, or prepared for their "last change." All these are subjects of prayer which we feel to be appropriate in such a case, and every sick

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[32] Albert Barnes' Notes, BibleHub.com, accessed April 17, 2014, http://biblehub.com/commentaries/barnes/james/5.htm.

person should avail themselves of the aid of those who have an interest at the throne of grace, that they may be obtained.[33]

It lies upon sick people as a duty to send for ministers, and to desire their assistance and their prayers. It is the duty of ministers to pray over the sick, when thus desired and called for. "Let them pray over them;" let their prayers be appropriate to their circumstance, and their intercessions be as becomes those who are affected with their calamities. In the times of miraculous healing, the sick were to be anointed with oil in the name of the Lord.

In Mark's gospel we read of the apostle's anointing with oil many that were sick, and healing them (Mark 6:13). And we have accounts of this being practiced in the church two hundred years after Christ; but then the gift of healing also accompanied it, and, when the miraculous gift ceased, this rite was laid aside. The papists indeed have made a sacrament of this, which they call the extreme unction. They use it, not to heal the sick, as it was used by the apostles; but as they generally run counter to scripture, in the appointments of their church, so here they ordain that this should be administered only to such as are at the very point of death. The apostle's anointing was in order to heal the disease; the papal anointing is for the expulsion of the relics of sin, and to enable the soul (as they pretend) the better to combat with "the prince of the power of the air" (Ephesians

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[33] Albert Barnes' Notes, BibleHub.com, accessed April 17, 2014, http://biblehub.com/commentaries/barnes/james/5.htm.

2:2). But it is surely much better to omit this anointing with oil than to turn it quite contrary to the purposes spoken of in scripture.[34]

Some Protestants have thought that this anointing was only permitted or approved by Christ, not instituted. But it should seem, by the words of James here, that it was a thing enjoined in cases where there was faith for healing. And some Protestants have argued for it with this view. It was not to be commonly used, not even in the apostolic age; and some have thought that it should not be wholly laid aside in any age, but that where there are extraordinary measures of faith in the person anointing, and in those who are anointed, an extraordinary blessing may attend the observance of this direction for the sick. However that is, there is one thing carefully to be observed here, that the saving of the sick is not attributed to the "anointing with oil," but to prayer: "The prayer of faith will save the sick." [35] In other words, the main way a believer receives God's healing power is through faith.

"Giving proper pastoral care to people means helping them become independent in faith in a healthy way." In a crisis, we are there for them. When they simply want to share what is going on in their lives, we are there. But maturity means they will gradually take responsibility for their own spiritual growth. Teaching people spiritual disciplines is one way we can perform this vital form of pastoral care. When people learn to pray, study

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[34] Strong In Faith, "Method's to Receive God's Healing Power," accessed October 27, 2015, http://stronginfaith.org/article.php?page=50.

[35] John Gill's Exposition of the Bible, BibleStudyTools.com, accessed April 17, 2014, http://www.biblestudytools.com/commentaries/gills-exposition-of-the-bible/james-5-14.html.

the Scriptures, tithe, and nurture their own relationship with the Lord, they become more and more mature.[36]

There is a difference between teaching and training. Teaching communicates the material, but training makes sure that it gets into the heart and the hand. Teaching alone will not build students. Add training, and you have got a powerful combination. The objective is to teach, train and equip people to help take care of one another as caregivers and ministers. A minister is a channel of forgiveness, grace, mercy, healing. A minister provides pastoral care. This is what God has called every believer to do and to be. The first step, then, in helping people move into ministry is to remind them of that, to tell them, "You are priests"; you are ministers.

While evangelism is a ministry to the nonbeliever, the ministry of healing most often takes place between believers. We are priests, called into each otber's lives to be agents of all kinds of healing—emotional, relational, physical, mental, vocational.

Healing is not the province of the specialized few; a secular study some years ago proved that. It was done to determine which school of counseling—Rogerian, Freudian, Jungian, and so on—produced the best results. The results were intriguing. The most effective counseling was provided not by the disciples of any of these professional schools, but by the control groups used in the study. Ordinary people—airline pilots, secretaries, housewives, businesspersons—with no therapy training, who simply spent time listening, produced better results than the professionals. It has been said that only about one person in ten seeking counseling has special needs requiring professional help.

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[36] Paul Anderson, "Using the Disciplines to Care," Leadership Books, ChristianityToday Library.com, accessed October 24, 2015, http://www.ctlibrary.com/ lebooks/ masteringministry/ masteringcare/mstmin02-10.html.

The other 90 percent are well served by talking to a sympathetic lay person. For instance, early in this century, there was no cure for alcoholism. It was not until two untrained laypersons discovered the Twelve Steps of Alcoholics Anonymous that there was any concrete program for recovery.[37]

The Jesus who said, "Come unto me, all you who are heavy laden (Matthew 11:28)" also said, "Go into all the world (Matthew 28:19)." Our call to discipleship includes the command to go. We are sent forth in mission. As we grow in our relationship with Christ, Jesus will continue to use us in the lives of others. Jesus will work in and through us. He will guide us to opportunities, prompt us to meet needs, and give us wisdom and endurance as we care for people. Our example and attitudes, as well as our actions, will reflect the character of God and God will be glorified by what is accomplished and by how it is done.

Based on personal experience, caregivers have many roles. The role changes as the patient's needs change during and after treatment. Caregivers serve as home health aides and companions. They may help feed, dress, and bathe the patient. Caregivers arrange schedules, manage insurance issues, and provide transportation. They are legal assistants, financial managers, and housekeepers. They often have to take over the duties of the person who is being cared for and still meet the needs of other family members and themselves. As a caregiver, one has a huge influence – both positive and negative – on how the patient deals with their illness. The caregiver's encouragement can help the

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[37] B. Larson, *Helping People Care for One Another, In Mastering Pastoral Care* (Portland, OR: Multnomah Press, 1990), 119-134.

patient stick with a demanding treatment plan and take other steps to get well, such as eating healthy meals or getting enough rest.

The patient faces many new challenges. As the caregiver, one can help the patient deal with these challenges and get through any problems that arise. The best way to prioritize and manage problems is to first try to understand the problem as well as the desired result. Caregivers who are realistic, positive, careful, creative, focused, and flexible are sources of strength and security for people who need the care of a caregiver. This is pastoral care at its best.

CHAPTER THREE

HISTORICAL FOUNDATIONS

When this minister looks at who he is in ministry and where he is in ministry, and sees how his educational and professional development come together; he identifies a historical foundation for the project he is proposing. He sees where providing pastoral care and counseling as a caregiver has played a major part to form his focus in ministry—the need to bring awareness to faith-based leaders health-care professionals on providing emotional and spiritual support as caregivers.

Being a pastoral caregiver he certainly knows something about providing emotional and spiritual support to those who have experience grief and loss. During a four year span as a staff chaplain in a hospital setting, he averaged 190 deaths a year serving as chaplain to them and witnessing many of them die.

It is vital that faith-based leaders and healthcare professionals have an understanding of how to deal with loss and grief as well as emotional issues when it comes to caregiving. Faith-based leaders not only need to know how to convey the word of God, but to provide spiritual and emotional support to caregivers. Before they can do that, they need to be trained. It is his contention that effective ministry is developed through mutual learning and growth, and serves as an important foundation for clinical training and pastoral care and counseling. Faith-based leaders and healthcare

professionals play an important role in providing emotional and spiritual support as caregivers. It is essential that they nurture and develop relationships as caregivers.

If aforementioned leaders or professionals want to be of real help in their contact with people, he or she has to be a professional with special information, special training, and special abilities.[1] The minister or faith-based leader and healthcare professional who cares for people is called to be skillful but not a handyperson, knowledgeable but not a pretender, a professional but not a manipulator. When he or she is able to deny him or herself, to be faithful and to understand the meaning of human suffering, then the person who is cared for will discover that through the hands of those who want to be of help, God shows his tender love for them.[2]

In reflecting upon his ministerial context, there is something about the brokenness of people in his context, especially the care of caregivers that he finds himself identifying with. From his observation, he attempts to address the topic of providing pastoral care and counseling as a caregiver. As one who is a pastoral caregiver in a variety of ways, including that of the more formal and structured ministry of pastoral care and counseling, he acknowledges that he is an adequate counselor concerning many issues, however he is not always sure he has counsel for his own brokenness. That is to say, he has some idea of what to offer by way of care to others, but he is not always sure of what to offer himself by way of care. In Henri Nouwen's book *The Wounded Healer*, he contends that "the minister is called to recognize the sufferings of his time in his own heart and make that recognition the starting point of his service. In other words, the minister must be

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[1] Henri J. M. Nouwen, *Creative Ministry* (Garden City, NY: Image Books, 1971), 64.

[2] Henri J. M. Nouwen, 64.

willing to go beyond his professional role and leave himself open as a fellow human being with the same wounds and suffering."[3]

One of the prevailing traits in his ministry is his overwhelming desire to serve people, to help them deepen their relationship with God, and to contribute to the growth of all faith communities. It is his desire to articulate a theology of spiritual care that is integrated with a theory of pastoral practice. He seeks to connect to the ministry of Jesus as He loved, cared, and healed ordinary people. But his theology has to be large enough to accept the theology of those whom he serves. If he cannot support a patient (or family member or healthcare professional) in his or her theology, then he cannot serve as a multi-faith professional chaplain when it comes to caregiving. In order to be an effective multi-faith chaplain, he needs to be secure in his own belief system. He also needs to be able to be open to understanding and interpreting the theology of any patient, family member or staff person with whom he come into contact. He has to be open to other people's theology and help them through using their belief system, not his own.[4]

So it is with some fear and trembling, but also with gratitude that this task was approached in the hope that the caregiver might receive pastoral care and counsel for their own brokenness. In hope also, the caregiver might receive some guidance to help them avoid the breakdown that sometimes occurs in the lives and ministry of those who are caregivers.

As a minister he has always had a great interest in training and development in teaching, preaching, Christian Education, Pastoral Care and Counseling. It was during his

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[3] Henri J.M. Nouwen, *The Wounded Healer* (Garden City, NY: Image Books, 1979), xvi.

[4] Stephen B. Roberts, *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook* (Woodstock, VT: Skylight Paths, 2012), 5.

first pastorate that he began to see the importance of leadership development. Through his experiences as a pastor and chaplain, he has personally been sought, recognized and called forth as a person with leadership potential. As a direct result of what has been done to and for him, he in turn, continues seeking to recognize and call forth the potential of persons, providing opportunities for their training and growth. He understands that it is impossible to be an effective pastor without properly trained and enthusiastic leadership. Jesus, Himself, chose twelve disciples, then seventy (Luke 10:1), and dedicated his entire earthly ministry to providing opportunities for training and growth for three and one half years before he ascended back to His Father. Effective ministry is borne through mutual learning and growth, and serves as an important foundation for clinical training and pastoral care and counseling. As a chaplain, caregiving is his profession.

Who are caregivers, and what do they do? A caregiver is an *unpaid* or paid relative or friend who helps a family member or another individual with a disability or impairment with his or her activities of daily living, as well as gives them physical and emotional care. Any person with a health impairment might use caregiving services to address their difficulties. Caregivers may be spouses, partners, family members, or close friends.[5] Most often, they are not trained for the caregiver job. Many times, they may be the lifeline of the person who is disabled. Here are a few things caregivers might help the person who is disabled do: Shop for and prepare food, eat, take medicines, bathe, groom, and dress, use the bathroom, clean house, do laundry, and pay bills. As well as find emotional support, get to and from doctor's appointments, tests, and treatments; manage

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[5] The Free Dictionary By Farlex, accessed March 2, 2014, http://www.thefreedictionary.com/caregivers.

medical problems at home, coordinate cancer care, and decide when to seek health care or see a doctor for new problems.[6]

All of this work costs caregivers time and money. There may also be a cost to the caregiver's health and well-being, but often the caregiver just keeps doing what needs to be done and may suffer in silence. You may be glad to put the well-being of the person who is disabled above your own well-being, and your love for this person may give you the energy and drive you need to help them through their difficult time. Still, no matter how you feel about it, caregiving is a hard job! And many caregivers are there for their loved one 24 hours a day for months or even years. Caregiving can be rewarding, challenging, confusing and overwhelming all at the same time.[7]

Caregiving has a long and complex history. But there are certain themes that repeat themselves throughout its history. In order to understand what caregiving means in our age, it is necessary to understand some of the historical events that have colored the connotation of the word. When people say "Caregiving", they have not only the simple denoted meaning of 'being there for someone who needs to be taken care of' in their mind, they also have within them, and of which they are more or less aware, the

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[6] American Cancer Society, Cancer.org, accessed March 2, 2014, http://www.cancer.org/treatment/caregivers/caregiving/whatyouneedtoknow/what-you-need-to-know-as-a-cancer-caregiver-who-and-what-are-caregivers.

[7] American Cancer Society, Cancer.org, accessed March 2, 2014, http://www.cancer.org/treatment/caregivers/caregiving/whatyouneedtoknow/what-you-need-to-know-as-a-cancer-caregiver-who-and-what-are-caregivers.

connotations of a lifetime of nuances, both conscious and unconscious, which color and shape their own understanding and use of the word.[8]

Some of the themes revealed by the study of the history of caregiving may be surprising. Those that are considered to be especially significant might be summarized as follows:

Caregiving is embedded in the human instinct to protect one's close family. Taking care of your own family is what every human being is expected to do; and behind that natural behavior lays the natural effect of physical touch, that is, the naturally bonding resulting directly from the affectionate touch among family members. It is this human impulse that lies behind all forms of hospitality. People generally believe, sometimes fiercely, in taking care of their own family –but some cultures then dictate: "and no one else!" Part of their notion of the protection of the closed circle of their family implies protection from outside threats from strangers, whatever their character.[9]

Caregiving has the motivating energy to take care of one's family members, when extended beyond the home to others. Sometimes caregiving goes beyond the security and sanctity of the personal home, as when the act of caregiving is expanded to include those who are not part of the family but are guests in the home. People come into the home as guests. And the security and sanctity of the home is normally expected to be extended to protect them. It is a natural social value. It is a matter of honor and self-respect as much

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[8] Lynn Wilson, "Caregiving Through the Ages And What the Future Holds," The CareGiver Partnership, accessed, October 24, 2015, http://blog.caregiverpartnership.com/2013/11/caregiving-through-ages-and-what-future.html.

[9] Lynn Wilson, "Caregiving Through the Ages And What the Future Holds," The CareGiver Partnership, accessed, October 24, 2015, http://blog.caregiverpartnership.com/2013/11/caregiving-through-ages-and-what-future.html.

as it is a matter of social responsibility to take care of the non-family member who find themselves at the home of a family not their own.[10]

Caregiving, in the public sense as we know it today, historically was a choice that was made consciously and intentionally of Christians specifically based upon the teaching of Jesus. There are those to whom the caregiver reaches out to provide the same level of personal, attentive care that is rooted in natural human attitudes and the natural experience of a mother and a father towards their children. "The act of extending caregiving beyond the family, beyond the home to the stranger – was the revolutionary social concept that was what set Abraham apart, and became a common impression Jesus Christ introduced first to the Middle East and then to Western humanity and from there to the whole world through the Catholic Church" (which curiously does not choose to take much credit for it).[11]

Caregiving historically has been in most cases the chosen vocational activity of an individual. "That choice and the enormous energy that has driven the lifestyle it implies has usually stemmed from two points. The first is nature: a recognizable personality characteristic of a specific individual: the intellectual, emotional and physical inclination to take care of another person. The second source is supernatural: within the Catholic tradition – that is, that choice to provide caregiving was accepted, recognized, justified and promoted on the social basis of Catholic theological values. The exercise and promotion of this choice was clearly evident in the heroic practice of caregiving by

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[10] The President's Council on Bioethics Washington, D.C. September 2005, www.bioethics.gov,"Taking Care: Ethical Caregiving Our Aging Society," The Ethics of Caregiving: General Principles, Chapter 3, accessed October 24, 2015, https://bioethicsarchive.georgetown.edu/pcbe/reports/taking_care/chapter3.htm.

[11] Martin E. Marty, "Christianity," Encyclopedia Britannica, accessed October 24, 2015, http://www.britannica.com/topic/Christianity.

individual persons, usually drawn from the common level of society. Frequently, but not always, these individuals were formally religious individuals, that is, they belonged to a Catholic religious group. Their activity often led to the founding of social institutions."[12]

Hospitals are a Catholic social invention.[13] The overall factor is that within the Western tradition of civilization, institutionalized caregiving, that is, what today we regard as the hospital system, is the direct and explicit result of the specific charitable projects of some of the early Christians of Rome. These individuals took the exhortations of Jesus to care for the sick, bury the dead and comfort the grieving to heart. They took the idea of comforting the grieving to heart and founded the first 'hospitality centers'. These centers were then systematically promoted by the early Catholic Church, and finally evolved away from the church and into the present day civil and secular hospital system, which is mostly composed of secular technological centers in which caregiving is not a primary consideration, if there is any official place for it at all.[14]

Caregiving, in this formal sense, was a devout, and often courageous, spiritual practice of particular individuals usually counted among the common people, the laity and religious, of the Catholic Church. But this devout practice of individual caregivers was repeatedly and systematically undermined, and opposed by high-ranking Catholic Church persons. The history of caregiving reveals that time and time again high-ranking

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[12] Martin E. Marty, Christianity," Encyclopedia Britannica, accessed October 24, 2015, http://www.britannica.com/topic/Christianity.

[13] Bill Federer, "Who invented hospitals…and Why? Religious Convictions and the History of Healthcare," accessed October 24, 2015, http://archive.constantcontact.com/fs155/ 1108762609255/ archive/1116344358976.html.

[14] Bill Federer, "Who invented hospitals…and Why? Religious Convictions and the History of Healthcare," accessed October 24, 2015, http://archive.constantcontact.com/fs155/1108762609255/archive /1116344358976.html.

church officials intervened with the intent to stop the direct caregiving work of individual Christians, who were usually but not always religious women. The repeated opposition of church authority to caregiving, the absolute lack of any real support from the hierarchy, and failure of the clergy to promote caregiving gradually sapped the energy of this pious practice of caregivers in ecclesiastical history. The church persons usually managed to imprison those who tried to be caregivers behind cloister grilles and thus, with complete indifference to the needs of the common people, inhibited and eventually destroyed the pious practice of caregiving that the members of the early church had tried to give people.[15]

Caregiving has been pushed back to its original position in the face of all these developments: free person-to-person, individualized caregiving, outside of institutionalized settings, by individual persons, sometimes grouped within a community organization. "Caregiving is unfortunately not presumed to be the field of Medicine (although there are some genuinely caring physicians), nor of Nursing (although there are some genuinely caring nurses), nor of the Hospital (which has become a very high-priced technology center which has no official room for caring), nor of Social Service (which has become a highly bureaucratized and money based civil service (although there are some genuinely caring social workers). The opposition to caregiving has been transferred to the state. For self-oriented reasons the state attempts regulation of caregiving but in a

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[15] Bill Federer, "Who invented hospitals…and Why? Religious Convictions and the History of Healthcare," accessed October 24, 2015, http://archive.constantcontact.com/fs155/ 1108762609255/ archive/1116344358976.html.

desultory fashion. And today caregiving faces some degree of threat from the more or less litigious character of North American society."[16]

Caregiving has returned to its origins. Through centuries of changes that saw hospitals degrade then be restored as secular, for-profit institutions, caregiving returned to its roots as individualized care outside of institutionalized settings. Caregiving today is practiced as the free extension of the natural impulse in an individual person to care for another human being. It is the action of individual persons, some motivated by natural impulse, and others still motivated by theological or other moral values. Caregiving is largely practiced outside the formal service of the church as well as of medicine, nursing, social service and hospitals. (Although it may be practiced by religious, doctors, nurses and social workers as well as regular people.) It is ignored by some institutions, tolerated by other institutions, and sometimes welcomed by yet others. The exercise of caregiving is, perhaps, most evident in individuals who choose to provide caregiving to the sick and dying under the protection of various community service programs.[17]

Caregiving found a degree of focused motivation in the myriad of self-help and focused support groups that blanket the North America social service scene. The natural impulse to help; even divested of its religious motivation, still moves individuals to dedicate themselves to the support of others. Taking a signal from the 'scientific' orientation embraced by social work in the wake of the bankruptcy of the caregiving system initiated by Luther, the natural inclination to take care of others tended to find

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[16] "Transforming Practice," The Future of Nursing: Leading Change Advancing Health (2011), The National Academies Press, accessed October 26, 2015, http://www.nap.edu/read/12956/chapter/8.

[17] Lynn Wilson, "The CareGiver Partnership: Caregiving Through the Ages and What the Future Holds," accessed October 26, 2015, http://www.prweb.com/releases/2013/11/prweb11349410.htm.

satisfaction in the establishment of a vast network of peripheral support groups serving specifically identified segments of the suffering community. These groups of focused service were soon abandoned by the historical choice of Social Service to focus on broad bureaucratic social goals, such as 'the elimination of ignorance, poverty, war and mental illness, rather than direct service goals to the sick and suffering. The choice was considered to be more efficient.[18]

Today, as in the past, caregiving is practiced as an unrestricted extension of the natural impulse to care for another person, sometimes inspired by theological or other moral values. Informal or family caregivers — who may take care of the elderly or disabled or may be grandparents raising their grandchildren — typically refers to people who are not paid to provide care. Approximately 66 million caregivers make up 29 percent of the U.S. adult population providing care to someone who is ill, disabled or aged, according to the Family Caregiver Alliance.[19]

Here are some of the more common challenges caregivers may have to deal with while helping a loved one with cancer. It may help one to know that caregivers who take care of their own needs and get the information, help, and support they need are better prepared to take care of their loved ones. Some ideas will be given on how one can take care of oneself and find the support and help they need. Some tips will also be given on how to be ready for some of the problems that might come up. Being a caregiver is a tough job, but it's an important and rewarding one, too. There are some ways to make one's work easier and more effective. The following topics will be discussed:

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[18] Greg Ogden, "Breaking Free: From Caregiver to Equipper," accessed October 26, 2015, http://gregogden.com/PDFs/BreakingFree.pdf.

[19] Lynn Wilson, "The CareGiver Partnership: Caregiving Through the Ages and What the Future Holds," accessed October 26, 2015, http://www.prweb.com/releases/2013/11/prweb11349410.htm.

Communication, Understanding the Health Care System, Making health decisions, Long-distance caregiving, the treatment timeline, staying organized, Taking care of yourself, asking for help, Job, Insurance, money concerns, Legal issues, and where you can get more information[20]

However, some benefits to the caregiving experience. New research reports gains in cognitive function in older women who provide informal (unpaid) care on a continuing basis. This cross-sectional study tested over 900 participants at baseline and again after two years for memory and processing speed, functions which are necessary for many caregiving tasks. The participants were divided into three groups, those who were caregivers over the entire two-year period, those who were caregivers at the start of the study but not at the two-year follow-up, and those who were not caregivers at any time during the research period. At follow-up, those who were caregivers throughout the study had the highest scores for both cognitive functions but also the highest reported levels of stress, while those participants who were not caregivers at any time during the study had the lowest scores for both cognitive functions and the lowest reported levels of stress. These results are consistent with the healthy caregiver hypothesis which states that while those older adults who are more likely to be caregivers are healthier to start with, it is the work of caregiving that helps keep them healthier than older adults who are not

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[20] American Cancer Society, Cancer.org, accessed March 2, 2014, http://www.cancer.org/treatment/ caregivers/caregiving/whatyouneedtoknow/what-you-need-to-know-as-a-cancer-caregiver-who-and-what-are-caregivers.

caregivers. This model contrasts with the long-held idea that the stress of caregiving results in poorer functioning over time.[21]

Although caregiving can be satisfying for many, it is obviously stressful as well. There are, however, strategies that caregivers and communities can use to reduce the effects of this added stress.[22] Information, resources and support are often available through senior centers and local public health departments, but more research is needed to determine what services are helpful.

The following are some ways what one can do to prevent or relieve stress: Find out about community caregiving resources; Ask for and accept help; Stay in touch with friends and family. Social activities can help you feel connected and may reduce stress; Find time for exercise most days of the week; Prioritize, make lists and establish a daily routine; Look to faith-based groups for support and help; Join a support group for caregivers in your situation (like caring for a person with dementia). Many support groups can be found in the community or on the Internet; see your doctor for a checkup. Talk to him or her about symptoms of depression or sickness you may be having; Try to get enough sleep and rest; Eat a healthy diet rich in fruits, vegetables, and whole grains and low in saturated fat; Ask your doctor about taking a multiple vitamins and take one day at a time.[23]

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[21]Bertrand, R.M., Saczynski, J.S., Mezzacappa, C., Hulse, M., Ensrud, K., & Fredman, L. (2011). Caregiving and cognitive function in older women: Evidence for the healthy caregiver hypothesis. *Journal of Aging and Health,* 24(1), 48-66.

[22] At Home Care, "Caregiver Tips For In-Home Care," accessed October 22, 2015, http://www.athomecarestlouis.com/caregiver-tips.html.

[23] "Caregiving," Medicinenet.com, accessed April 15, 2012. http://www.medicinenet.com/caregiving/article.htm.

Caregiving involves many challenges. One often needs to master new skills. One may need to develop new ways of relating to a family member if his or her ability to communicate or remember is comprised by illness. One may have to make tough decisions. But often one of the greatest challenges is taking care of self. Too often caregivers neglect their own health and well-being, and put their own needs on the back burner. Sometimes caregivers become the second victim of the disease that afflicts their family member.[24] According to a National Academy of Sciences Report, a caregiver of a person diagnosed with dementia finds his or her own immune system depressed for up to three years after the caregiving ends. This depressed immune system contributes to chronic illness for the caregiver. A caregiver can even find his or her own life shortened, as the extreme stresses of caregiving can take as many as ten years off a family caregiver's life.[25] Usually, they cannot stop the impact of a chronic illness on a family member. However, they are responsible for their own self-care. When one takes care of themselves, everyone benefits.[26]

It is important to be clear about what one can and cannot change. For example, one will not be able to change a person who has always been demanding and inflexible, but one can control how they respond to that person's demand. One can accept—"let go" of—the things they cannot change. Managing their self-care also means they seek solutions to what they can change. Caregivers must learn from their emotions by realizing

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[24] Vicki L. Schmall, Marilyn Cleland, and Marilyn Sturdevant, *The Caregiver Helpbook* (Portland, OR: Legacy, 2000), 1.

[25] National Family Caregivers Association, "Caregiving Statistics," accessed October 28, 2015, http://www.nfcacares.org/who_are_family_caregivers/care_giving_statistics.cfm.

[26] Vicki L. Schmall, Marilyn Cleland, and Marilyn Sturdevant, *The Caregiver Helpbook* (Portland, OR: Legacy, 2000), 1.

there will be emotional ups and downs. They must listen to their emotions and what they are telling them. Do not bottle up their emotions. Suppressing or denying their feelings decreases energy; causes irritability, depression, and physical problems; and affects their judgment and ability to make the best decisions. Also, do not strike out at others. The caregiver should be in control of their emotions; their emotions should not control them.[27]

An important part of self-care is knowing when one needs help and how to find it. Help can be from community resources, family and friends, or professionals. Most important is that one not wait until they are hanging at the end of their rope before they get help. Do not wait until one is overwhelmed or exhausted, or one's health is failing. Reaching out for help, when needed, is a sign of personal strength.[28]

Each one of us has a reservoir of strength. The challenge is to identify our strengths and build on them. One must plan strategies that will help them cope, change, and reduce stress. As caregivers, we no doubt have increased stress in our lives, whether we are caring for a mother with early Parkinson's disease, who is still able to care for her personal needs, or a spouse who does not recoguize them because of advanced Alzheimer's disease. Each caregiving situation is unique. What is stressful for one may not be stressful for someone else. The stress one feels is not only the result of their caregiving situation; it is also one's perception of it. Their stress will increase or decrease

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[27] Vicki L. Schmall, Marilyn Cleland, and Marilyn Sturdevant, *The Caregiver Helpbook* (Portland, OR: Legacy, 2000), 3.

[28] Vicki L. Schmall, Marilyn Cleland, and Marilyn Sturdevant, 3.

depending on how they perceive their circumstances. And their perception will affect how they respond.[29]

One's level of stress is influenced by many factors, including: whether their caregiving is voluntary or not; their relationship with the care receiver; their coping abilities; their caregiving situation; and whether support is available.[30]

Many people become caregivers voluntarily. Others acquire the role because no one else is available. When one becomes a caregiver voluntarily, they are making a choice. However, if one "inherited" the job and feels they had no choice; the chances are greater for experiencing strain, distress, and resentment.

Little did this minister know that shortly after enrolling as a Doctor of Ministry student at United Theological Seminary that his brother would be diagnosed with cancer, and that he himself would become a caregiver to his own brother. Fortunately, between the two of them, they had a good relationship and were able to communicate openly, minimizing some of the potential stress. One cannot always think about a caregiving relationship in advance, but if one can, it has greater potential for success. If one's relationship with the care receiver has been difficult, becoming a caregiver is more of a challenge. If the care receiver has always been demanding and controlling, one will probably feel more stress, anger, and resentment. How one has coped with stress in the past predicts how they will cope now. It is important to identify one's current coping

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[29] Vicki L. Schmall, Marilyn Cleland, and Marilyn Sturdevant, *The Caregiver Helpbook* (Portland, OR: Legacy, 2000), 16.

[30] HelpGuide.org, "Effective Communication," accessed October 23, 2015, http://www.helpguide.org/articles/relationships/effective-communication.htm.

strengths and build on them. Learning new coping skills also will help make their caregiving situation less stressful.[31]

Communicating effectively with others is another important factor when it comes to caregiving. Many caregivers say that lack of communication is the underlying problem in misunderstandings and poor relationships with family members, friends, and health care professionals. It does not have to be this way. Although we cannot cure chronic illness, we can do something about how effectively we communicate with others. Good communication skills are critical in caregiving. Over the course of long-term illness we must rely on our communication skills to obtain and share information, to adapt to change, to ask for what we need, and to stay connected to others. Our effectiveness as communicators depends on how well we listen and what we think and feel, how we come across to others, what we choose not to say and whether others feel we respect their rights and feelings.[32]

In mastering caregiving transitions, one's attitude toward the challenges of caregiving will make it easier or more difficult for one to deal with them. If one has an optimistic attitude, one is more likely to expect that a positive outcome is possible and to focus on what one can do when faced with a change or decision. With a pessimistic attitude, focus is on the negative. Being optimistic does not mean one suppresses their feelings when dealing with a difficult situation or decision. It is perfectly normal to feel

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[31] Family Caregiver Alliance, "Taking Care of YOU: Self-Care for Family Caregivers," accessed October 23, 2015, https://caregiver.org/taking-care-you-self-care-family-caregivers.

[32] HelpGuide.org, "Effective Communication," accessed October 23, 2015, http://www.helpguide.org/articles/relationships/effective-communication.htm.

discouraged, angry, fearful, anxious, sad and uncertain. However, people who are optimistic get beyond those feelings to make the most of a situation.[33]

An optimistic attitude helps an individual avoid depression, helps them focus, and motivates one to move forward. An optimistic attitude may help an individual avoid getting sick during stressful times. On the other hand, a person with a pessimistic attitude—for example, thinking nothing can be done—will probably keep them from looking for ways to deal with the changes they face, and will increase feelings of helpfulness. And, it might even put their health at risk. Optimism creates possibilities and hope; pessimism destroys them. How one views events can either enhance or undermine their ability to master a transition.[34]

The goal is to achieve a positive attitude based on present reality. Because one has control over their attitude, reaching this goal is up to the individual. If one's current attitude is based on wishful thinking about the past, one can change it by how they deal with change and transition.[35]

Pastoral conversation is another key factor when it comes to providing care. To share in pastoral conversation is an extraordinary gift. We are invited into the most intimate spaces where people talk about the very nature of their being human. They share

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[33] Caregiver Resource Network, "Managing the Emotions of Caregiver Transitions," accessed October 23, 2015. http://www.caregiverresource.net/uploads/files/packets/Managingthe Emotionsof CaregiverTransitions_Comp.pdf.

[34] Vicki L. Schmall, Marilyn Cleland, and Marilyn Sturdevant, *The Caregiver Helpbook* (Portland, OR: Legacy, 2000), 125.

[35] Vicki L. Schmall, Marilyn Cleland, and Marilyn Sturdevant, *The Caregiver Helpbook* (Portland, OR: Legacy, 2000), 132.

their joy and they share their pain. They reach hard-to-find words of genuine faith. If one is alert to it, they will be blessed with life-shaping wisdom.[36]

When two or more people engage each other in meaningful ways, conversation is happening. It can involve a sharing of thought, question, silence, insight, concern, laughter, forgiveness, confusion, celebration, and much more. All of us want to engage in significant conversation about our lives in safe settings and with people we trust. We all want to be heard and valued in our language. The primary concern of "pastoral" conversations is care of persons.[37]

If one wants to improve their conversational ability, a starting point is to attend to and tell their own life story. We all want and need our own lives to be heard. Taking the time to tell the story of one's own life in a journal and then to another person is good preparation for conversation not least because if frees one to be present to the other. It is important to spend significant time exploring and naming the story of one's life.[38]

Along with exploring one's own story, practice pastoral conversation. Interview a friend about a particular experience in his or her life, such as birth, death, marriage, divorce, separation, job loss, injury, achievement, celebration, or life transition. It might be found helpful to sit somewhere quietly after the conversation and write down what happened—not just a summary of the content of the conversation but what was done, what questions were asked, how one acted, and what effect that had on the conversation.

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[36] Douglas Purnell, *Conversation As Ministry: Stories and Strategies for Confident Caregiving* (Cleveland, OH: Pilgrim Press, 2003), 1.

[37] Douglas Purnell, *Conversation As Ministry: Stories and Strategies for Confident Caregiving* (Cleveland, OH: Pilgrim Press, 2003), 6.

[38] Douglas Purnell, *Conversation As Ministry: Stories and Strategies for Confident Caregiving* (Cleveland, OH: Pilgrim Press, 2003), 95.

Reflect on one's intention in shaping questions and responses and their outcome in guiding the conversation. The questions that emerge from this conversation are important for engaging in deep conversation in the future.[39]

Feelings are the caregiver's special gifts that make it possible to offer yourself generously and lovingly to another. Self-sacrifice and kindness are special qualities caregivers bring to the bedside of the dying. They are not without costs, though. One way to reduce this burden is to pay close attention to one's own emotions. These energy streams rise and fall with all the daily situations faced by the caregiver. If allowed to flow unimpeded by cultural strictures, our feelings can aid and abet the deep commitment we make to caring for another. To participate in the final drama of our loved one's life is to open the door to great courage and joy. Illness and death do not negate life, but are an essential part of it. Caregiving works as a celebration of all of the darkness of disease and the lightness of human connection, and not only a fragment. In this way we honor the human spirit in each of us. The ultimate gift of caregiving is that one can wholly and completely love, accept and respect oneself and all their loved ones without reservation.[40]

As the American population ages, the number of caregivers and the demands placed on them will continue to grow. According to the AARP, as boomers age and the caregiver ratio declines, family support will be critical to maintaining independence and reducing nursing home use among older people with disabilities. While Americans are

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[39] Douglas Purnell, *Conversation As Ministry: Stories and Strategies for Confident Caregiving* (Cleveland, OH: Pilgrim Press, 2003), 96.

[40] Nanette J. Davis, *Caregiving Our Loved Ones: Stories and Strategies That Will Change Your Life* (Bellingham, WA: House of Harmony Press, 2012), 217.

living longer, living well with chronic illness will be one of the biggest health challenges over the next 20 years.[41]

Lynn Wilson declares that, "As we see how caregiving has come full circle, the concept of aging in place — remaining at home safely and independently for as long as possible — is no longer a dream; it's becoming a necessity." Fall prevention and aging-in-place design, using technology to monitor and communicate, and innovation in home health care products and services are essential components of living well in the future.[42]

Sixty-five million people give care to chronically ill, elderly or disabled friends and family members every year. Caregiving involves many people: spouses, adult children—both sons and daughters, siblings, parents with sick children, even children who care for their parents and grandparents. Sixty-six percent of caregivers are women. Most commonly, an adult daughter, herself married and employed, provides care for her aging parent (s).[43] Caregivers may be raising their own children while helping aging parents, hence the term "sandwich generation."

Children also care for ill family members: One million four hundred thousand children ages eight to eighteen provide care for an adult relative. Seventy-two percent are

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[41] Andrew Scharlach, Historical Review - Counsel on Social Work Education, accessed, October 26, 2015, http://www.cswe.org/File.aspx?id=16911.

[42] Lynn Wilson, "The CareGiver Partnership: Caregiving Through the Ages and What the Future Holds," accessed October 26, 2015, http://www.prweb.com/releases/2013/11/prweb11349410.htm.

[43] National Family Caregivers Association, "Caregiving Statistics," accessed October 28, 2015, http://www.nfcacares.org/who_are_family_caregivers/care_giving_statistics.cfm.

caring for a parent or grandparent; and 64 percent live in the same household as their care recipient. Fortunately, most are not the sole caregiver.[44]

Parents dealing with a chronically ill child or disabled child live with stress. The emotional roller coaster begins at the first indication that their baby has health concerns, and the parents are plunged from joyful anticipation to fear and concern.

Forty years of scholarship and changing public policy on family and informal caregiving for older adults have brought us far, but we have far yet to go. Interest in family caregiving expanded in the 1970s with studies such as Troll's examinations of intergenerational family relationships(Troll, 1971), Cantor's (1991) hierarchical model of family care, Archbold's (1983) investigations of parent care, and the development of caregiver-burden measurement tools such as the widely used Zarit Burden Interview.[45]

The 1980s saw the conducting of the first national surveys of informal caregivers for disabled older adults—the U.S. Department of Health and Human Services' National Long Term Care Surveys (Stone et al., 1987) and the AARP/Travelers Foundation (1988) National Survey of Caregivers.[46]

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[44] National Family Caregivers Association, "Caregiving Statistics," accessed October 28, 2015, http://www.nfcacares.org/who_are_family_caregivers/care_giving_statistics.cfm.

[45] Andrew Scharlach, Historical Review - Counsel on Social Work Education, accessed, October 26, 2015, http://www.cswe.org/File.aspx?id=16911.

[46] Andrew Scharlach, Historical Review - Counsel on Social Work Education, accessed, October 26, 2015, http://www.cswe.org/File.aspx?id=16911.

The 1993 federal Family and Medical Leave Act made the United States one of the few countries to grant workers the right to unpaid leave in order to care for a parent, spouse, or child with a serious health condition.[47]

Alliance for Caregiving was founded in the United States in 1996; in conjunction with AARP, it conducted the Family Caregiving in the U.S. national survey in 1997. Several other studies of caregiving prevalence and needs also took place in the 1990s, as did a number of intensive, rigorously designed evaluations of interventions intended to alleviate caregiver distress (Brodaty et al., 1994; Mittelman et al., 1995) and more conceptually sophisticated explorations of the caregiving stress process (Pearlin et al., 1990).[48]

The last ten years has brought increasing attention to aging baby boomers with regard to both their current caregiving responsibilities and their own future care needs. The 2000 reauthorization of the Older Americans Act created the National Family Caregiver Support Program (NFCSP), allocating resources to providing support services to family caregivers.[49]

Support systems for family caregivers have been affected by changes that have made social work and nursing more managerial than clinical. Funding and regulatory constraints and an increased emphasis on individual accountability have shifted their emphasis to providing information and referrals rather than discharge planning and care

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[47] The Family and Medical Leave Act - Wage and Hour Division (WHD), United States Department of Labor, accessed October 26, 2015, http://www.dol.gov/whd/regs/compliance/1421.htm.

[48] Andrew Scharlach, Historical Review - Counsel on Social Work Education, accessed, October 26, 2015, http://www.cswe.org/File.aspx?id=16911.

[49] Andrew Scharlach, Historical Review - Counsel on Social Work Education, accessed, October 26, 2015, http://www.cswe.org/File.aspx?id=16911.

management. In general, families are on their own to a greater degree than they have been in decades.

Caregiving research has also changed, using increasingly sophisticated analytic tools to address complex conceptual models. For example, the Resources for Enhancing Alzheimer's Caregiver Health project evaluated interventions designed to reduce caregiver distress, whereas Medicaid's ongoing Cash and Counseling program examines the effect of long-term care policies and programs on family caregivers.[50]

Family caregivers have changed during the twenty years, reflecting national trends as well as greater options for care. The four most recent National Long Term Care surveys (Spillman & Black, 2005; Wolff & Kasper, 2006) and three national household caregiver surveys conducted in collaboration with AARP (AARP & The Travelers Foundation, 1988; National Alliance for Caregiving & AARP, 1997, 2004), revealed some relatively consistent trends in family life over the past 20 years:[51]

• Men have taken on more caregiving responsibilities, although women still make up more than 60% of caregivers.

• Like the general population, caregiving families have become more diverse racially and ethnically.

• Fewer caregivers are married than those 20 years ago, and fewer are caring for a spouse.

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[50] Andrew Scharlach, Historical Review - Counsel on Social Work Education, accessed, October 26, 2015, http://www.cswe.org/File.aspx?id=16911.

[51] Andrew Scharlach, Historical Review - Counsel on Social Work Education, accessed, October 26, 2015, http://www.cswe.org/File.aspx?id=16911.

• Fewer caregivers live with their care recipient, and more live at least 20 minutes away.

• Caregiving is more likely to be done by one person, and caregivers generally have less time for family or friends.

The kinds of care provided are changing as well. Today's primary caregivers frequently care for persons with high levels of disability, rather than shopping, transporting, and doing everyday tasks for more able older adults. Approximately 30% of all disabled older adults receive no human assistance of some kind, making use instead of assistive devices such as microwave ovens and walkers (Spillman & Black, 2005).[52]

As we look ahead, "families are changing at a startling pace. Changes in family composition, cultural diversity, geographic mobility, and societal norms, coupled with increasing numbers of older adults living with high levels of disability, are changing how caregiving for older adults is balanced among families, informal networks, and formal supports. Social policy, practice models, and empirical research have not kept pace with these changes. This country has yet to develop a comprehensive, integrated, long-term care system that views informal caregivers both as care partners and as service recipients in their own right. Moreover, recent policy changes designed to reduce government expenditures put families at risk for having to take on even greater care responsibilities. For better and for worse, communication and technologic interventions are gradually replacing some forms of direct human contact. It is still unclear whether older adults and

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[52] Andrew Scharlach, Historical Review - Counsel on Social Work Education, accessed, October 26, 2015, http://www.cswe.org/File.aspx?id=16911.

their caregivers will become more isolated or whether new social contracts within families and between families and society will arise, rooted in the belief that even disabled older adults have a contribution to make, that they deserve to have their basic needs met, and that families should not be solely responsible for meeting those needs. We have come a long way in the past four decades. We still have a long way to go."[53]

In the years ahead, the challenges of caring well for elderly persons-including and especially those suffering from debility and dementia-will become more apparent and more urgent. We may face a genuine caregiving crisis-with more needy individuals and fewer available caregivers, with growing costs of long-term care and fewer workers to support social programs, with longer periods of diminished function and the ever-present temptation to neglect or abandon those in need of constant attention. Looking ahead, it is thus incumbent upon us to ask: What constitutes good care, what makes it possible, and how can we become or support good caregivers?

In a certain sense, the answer is obvious; good care is possible when there are people willing to care, able to care, and having resources to care. Good care is possible when family members and friends make the sacrifices necessary to be caregivers, when health care professionals and social workers tend to the real needs of their patients, and when society does not leave families to provide completely for themselves.

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[53] Andrew Scharlach, Historical Review - Counsel on Social Work Education, accessed, October 26, 2015, http://www.cswe.org/File.aspx?id=16911.

CHAPTER FOUR

THEOLOGICAL FOUNDATIONS

This project "Bringing Awareness to Faith-Based Leaders and Healthcare Professionals on Providing Emotional and Spiritual Support as Caregivers" integrates a theological base for the expressed purpose of developing the project's theological paradigm. The project forges a theological collaboration between the theological principles of Contextual Theology and Pastoral Theology and Counseling. However fundamentals within the project are gathered from these theological realms to construct a theological foundation for the praxis and passion of the project.

Lourdino A. Yuzon stated in his article "Towards A Contextual Theology" that "contextualization is an essential dynamic of the Christian faith. This is to say, the essentials of contextual theology are derived from the way God has related God's-self to the world. Put simply, through the incarnation event, God comes to us and establishes us in life-affirming, life-giving and life-sustaining relationship with God's-self. The world is the object of God's unqualified and out-going love (John 3:16). God expressed God's love through an act of self-giving and in sharing our human experience (John 1:14). If the church is to touch peoples' lives with God's message in a meaningful way it must communicate that message incarnationally. Contextual theology reminds us that theology is not just a view of life, but also a way of life. And based on what God did in and

through Christ and is doing in the Spirit; that way of life should be incarnational through and through."[1]

We are there. We act. If there has been prior reflection on theology and pastoral care, it will inform our practice. As we are attentive to the Word, Christian faith will have its impact on the care we give.

Suffering and dying have potential to become a concluding stage of learning, wisdom, and growth in the human life even under the worst imaginable circumstances. This is not meant to suggest that suffering and death ought, therefore, to be pursued or celebrated as goods in their own right. It is to suggest, however, that both suffering and dying may occasion unexpected opportunities for growth, personal spiritual insight, the attainment of wisdom, and the potential to teach invaluable lessons to the living.[2]

Natalie Kertes Weaver in her book *The Theology of Suffering and Death* states that human beings, regardless of belief or creed, share the inevitability of death with one another. Everyone loses loved ones, and everyone stands to leave others behind in their own passing. This reality means that, while some people make caregiving a profession, all people have a vocation to care for others as well as themselves in illness, death, and bereavement. Yet, despite the universality of the call to caregiving, one of the greatest challenges in modern society remains lack of skill and language to deal with death.

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[1] Lourdino A. Yuzon, "Towards A Contextual Theology" CTC Bulletin, Christian Conference of Asia, accessed November 22, 2014, http://cca.org.hk/home/ctc/ctc94-02/1.yuzon.htm.

[2] Natalie Kertes Weaver, *The Theology of Suffering and Death* (London, UK: Routledge, 2013), 91.

Especially in the first world, advances in medical technology have removed death from the immediacy of home and relocated the dying to institutional settings.[3]

In agreement with Weaver, many of us today have lost a vital connection to the life cycle of birth and death, more and more cut off as we are from traditional community and extended family. Perhaps more than in previous eras, today people (professional and otherwise) are less equipped to deal with death holistically and constructively. As such, people today require a renewed skill set for facing their own mortality as well as that of others.[4]

The intention is to look at ways in which theological dialogue may be practically applied in the spiritual care of those enduring suffering and facing death. This represents a perspective shift to a focus on medical research, practitioner experience, and lessons in caregiving derived from end-of-life experts.[5] This shift is intentional and represents the operating assumption of this project that suffering engages both: firstly, the philosophical questions of meaning that theology attempts to respond to; and secondly, a practical need to engage suffering persons in concrete acts of compassionate care.[6]

Individuals who are suffering, particularly at the end of life, experience increased physical pain when spiritual and religious matters are inadequately addressed. In order to address and treat spiritual pain, caregivers (whether professional or personal) need to

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[3] Natalie Kertes Weaver, *The Theology of Suffering and Death* (London, UK: Routledge, 2013), 91.

[4] Natalie Kertes Weaver, *The Theology of Suffering and Death* (London, UK: Routledge, 2013), 92.

[5] Duke Institute on Care at the End of Life, "Key Topics on End-of-Life Care For African Americans," accessed October 22, 2015, https://divinity.duke.edu/sites/divinity.duke.edu/files/documents/tmc/KTFULL.pdf.

[6] Natalie Kertes Weaver, *The Theology of Suffering and Death* (London, UK: Routledge, 2013), 92.

know what an individual's spiritual pains actually are. The facts attained here is through the establishment of a trusting relationship between caregiver and patient in which open dialogue can occur. It is also important for caregivers to understand the religious faith of patients as well as possible because aspects of faith frequently influence the actual medical care one receives as well as the disposition of body and bio-matter.[7] "Without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person."[8]

Weaver goes on to say that the encounter between faith and suffering can provide opportunities for personal growth, compassionate deeds, and spiritual enlightenment, but the encounter is never easy. For most of us, thinking about death is scary and talking about it directly can be uncomfortable. One of the benefits of studying the theology of suffering is that this study can prepare people to deal with death in advance by equipping us with insight and resources that we can use when it is necessary. The human task is not to evade our circumstances. We could not do that even if we tried. The real task becomes to be renewed in our orientation to life itself, whatever it may bring.[9]

For caregivers, it is particularly critical to be able to approach self and others honestly and as we actually are. Such approach takes a maturity and wisdom, challenging us to be comfortable in our own mortality and willing to be a companion to others as they encounter their own fundamental limits of health and life. In this challenging work, it is

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[7] Natalie Kertes Weaver, *The Theology of Suffering and Death* (London, UK: Routledge, 2013), 97.

[8] Vandercreek, Larry, *Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific: Yes and No* (New York, NY: Haworth Pastoral Press 2002), 202.

[9] Natalie Kertes Weaver, *The Theology of Suffering and Death* (London, UK: Routledge, 2013), 105.

especially helpful to have a variety of tools to draw from, both to prepare for the encounter with suffering and also to employ in times of death and bereavement.[10]

This project, then, is an assortment of tools and resources for faith-based leaders and healthcare professionals, as well as the reader to use toward this preparation. All students, teachers, faith-based leaders and healthcare professionals concerning this material are encouraged to seek out additional resources that advance their study as well as to incorporate liberally into the learning process practical wisdom gained through professional experience and personal histories. Providing suggested resources is the objective for further research, practice, study in the classroom, in personal processing, in professional teams, and in practical application with the suffering, dying, and bereaved. The tools presented here represent only a small sampling of the numerous and excellent resources currently available.

The great reward for those who are so daring as to meet the challenge of caring for others is that they have exceptional opportunities to gain wisdom in advance of their own years and experience. This wisdom can become the foremost guide to living well, making good choices, building strong relationships, and valuing each moment as the treasure that it is.

In developing a model of spiritual fitness, it is important to examine the lack of health and wholeness within the inner life of the self. A practical theology of caregiving in relation to one's own needs as social, physical and spiritual persons is presented as a

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[10] Natalie Kertes Weaver, *The Theology of Suffering and Death* (London, UK: Routledge, 2013), 105.

basis for the achievement of spiritual fitness. The self is like a child within us, thriving on the nourishment of loving care rather than striving in completion.

Ray S. Anderson in his book *Spiritual Caregiving as Secular Sacrament* states that, "as caregivers, many of us lack the kind of nurturing love which we seek to give to others. It is one thing to meditate on the Scriptures which remind us of the love that God has for us. We need more than that. We need and must develop relationships in which we are the beneficiaries of the kind of love which we provide others. It is not a sign of weakness to need the love of others conveyed in real, personal ways. This need is for a fully positive personal relation in which, because we trust one another, we can think and feel and act together. Only in such a relation can we really be ourselves'."[11]

Anderson says that spiritual fitness continues to connect with the reality of life even when it sometimes brings pain and causes stress. Spiritual fitness empowers us to bear the heavy burdens of life rather than to choose those which feel weightless but may also lack meaning. Spiritual fitness is the discernment to know which burdens are worth bearing and which are not.[12]

It is felt that spiritual health is not obtained through denying human needs by means of starving the soul. Proper sustenance of the inner self fulfills needs while also creating healthy appetite! When Jesus promised "Blessed are those who hunger and thirst for righteousness, for they will be filled" (Matthew 5:6) it is the hunger for that which truly fulfills that receives the blessing, not a filling which quenches the thirst and kills the

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[11] Ray S. Anderson, *Spiritual Caregiving as Secular Sacrament: A Practical Theology for Professional Caregivers* (London, UK: Jessica Kingsley, 2003), 107.

[12] Ray S. Anderson, *Spiritual Caregiving as Secular Sacrament: A Practical Theology for Professional Caregivers* (London, UK: Jessica Kingsley, 2003), 111.

appetite. Healthy self-care is marked by a healthy appetite for sustaining love and healing grace.

The spiritual aspect of caregiving on the part of religious professionals is often too narrowly focused on improvement while, for clinical professionals in the caregiving field, mental health care is often too narrowly focused on overcoming anxiety, discomfort, or disease. The discipline of practical theology offers a paradigm of theological reflection and praxis which provides a more integrative approach by focusing on a more holistic view of human beings.[13]

According to DeLaune and Ladner, 2006, "Healthcare professionals are trusted with the holistic care of their clients. This means the nurses and other healthcare providers care for the soul and spirit as well as the soul and body. By caring for individuals in a way that acknowledges the mind-body-spirit connection, healthcare providers acknowledge the whole person. Spiritual care is a part of holistic care."[14]

Anderson goes on to say that spirituality lies deeper in the human soul than religious education. At the same time, spirituality goes further toward human wholeness and well-being than merely the removal of sickness, pain, and distress. Spirituality thus grows out of an integrative environment which includes both the physical and mental characteristics of personal being, grounded in social, personal, sexual, and psychical

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[13] Ray S. Anderson, *Spiritual Caregiving as Secular Sacrament: A Practical Theology for Professional Caregivers* (London, UK: Jessica Kingsley, 2003), 11.

[14] Jones and Bartlett Publishers, "Health and the Human Spirit," accessed October 24, 2015, Spirithttp://www.jblearning.com/samples/0763757616/57618_CH02_Pass2.pdf.

integration as a praxis of life.[15] According to DeLaune and Ladner, people throughout history have dealt with pain, illness and healing in spiritual ways. In many primitive cultures, a single individual simultaneously held the positions of priest, psychiatrist, and physician.[16]

Those who actually practice some form of spiritual ministry have more direct access to the primary subject of theological reflection on human nature than those who deal only with abstract concepts and constructs regarding persons.

At the center of the discussion of the nature of practical theology is the issue of the relation of theory to practice. If theory precedes and determines practice, then practice tends to be concerned primarily with methods, techniques and strategies for ministry, lacking theological substance. If practice takes priority over theory, ministry tends to be based on pragmatic results rather than prophetic revelation. A praxis approach does not ignore theory but develops theory in an interactional model with praxis. All good practice includes theory.[17]

"Behind the massive work of Karl Barth lies the dynamic interrelation hetween theory and praxis. The task of theology as Barth construed it is to clarify the

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[15] Ray S. Anderson, *Spiritual Caregiving as Secular Sacrament: A Practical Theology for Professional Caregivers* (London, UK: Jessica Kingsley, 2003), 11.

[16] Jones and Bartlett Publishers, "Health and the Humau Spirit," accessed October 24, 2015, Spirithttp://www.jblearning.com/samples/0763757616/57618_CH02_Pass2.pdf.

[17] Ray S. Anderson, *Spiritual Caregiving as Secular Sacrament: A Practical Theology for Professional Caregivers* (London, UK: Jessica Kingsley, 2003), 17.

presuppositions of church praxis. Praxis comes first precisely because God is 'No fifth wheel on the wagon, but the wheel that drives all wheels.'"[18]

It is viewed that the human person as endowed by God with a divine image which serves to promote self-worth, emotional health, and a strong and vital faith in the face of life's inevitable and irrational pain and suffering. The growth of the self requires care, not only self-care but also the care of others such as parents and family members who undertake responsibility for the development of the self through personal and social interactions. Sooner or later, each of us assumes the responsibility for our own self-care which entails, among other things, making wise choices with regard to the persons with whom we live and to whom we look for support, love and community.[19]

It is felt that the project of "Bringing Awareness to Faith-Based Leaders and Healthcare Professionals on Providing Emotional and Spiritual Support to Caregivers" must include the paradigms and principles of Christian Theology in order to possess a balanced theological foundation, which is adequate to meet the needs of his context, church and community.

"Christian theology has been defined in various ways by the masters of this science." William Burton Pope defines it as "the science of God and divine things, based upon the revelation made to mankind in Jesus Christ, and variously systematized within the Christian Church." Others define it as follows: "Christian Theology, or Dogmatics, as it is technically called, is that branch of theological science which aims to give systematic

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[18] Ray S. Anderson, *Spiritual Caregiving as Secular Sacrament: A Practical Theology for Professional Caregivers* (London, UK: Jessica Kingsley, 2003), 17.

[19] Ray S. Anderson, *Spiritual Caregiving as Secular Sacrament: A Practical Theology for Professional Caregivers* (London, UK: Jessica Kingsley, 2003), 20.

expression to the doctrines of the Christian faith." – William Adams Brown.[20] Meaning, the study of Christian belief and practice focusing mostly on the writings of the Old and New Testament as well as on the historic traditions of Christians using biblical exegesis, rational analysis and argument.

In an effort to help incorporate the historic tradition into present and future practice, Howard W. Stone in his book *Theological Context for Pastoral Caregiving,* proposes ten theses suggestive of the shape that pastoral care can take today. These theses, of course, draw upon both the traditional and the nondirective models, and especially upon Howard Clinebell's revised model, but they attempt also to integrate more fully the four historical functions of pastoral care.[21]

1. Pastoral care recognizes liturgy, ritual, confession, and traditional and contemporary Christian resources as beneficial components. It is not shy about offering prayers and sound spiritual healing for the sick. It draws from the discipline of spiritual direction. It reemphasizes the work of the Spirit.
2. Pastoral care does not view personality change as the primary goal of its work. Sometimes, it is supportive of the person; at other times it helps people stretch to use to the fullest their God-given resources and strengths, while at the same time recognizing that people are finite and that the source of all growth lies outside themselves. Finally, it recognizes that the pastoral care goals of all Christians are growth in faith and loving service to others.

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[20] H. Orton Wiley, "Christian Theology" Chapter 1, The Wesley Center Online, accessed October 27, 2015, http://wesley.nnu.edu/other-theologians/henry-orton-wiley/h-orton-wiley-christian-theology-chapter-1/.

[21] Howard W. Stone, *Theological Context for Pastoral Caregiving: Word in Deed* (Binghamton, NY: Haworth Press, 1996), 12.

3. Pastoral care is not morally or theologically neutral. It operates from a Christian perspective and, when appropriate and effective, speaks to the parishioner from this perspective. It incorporates moral guidance and spiritual direction. In short, pastoral care does not stop at teaching the skills of effective living; it points also to a moral life, a faithful life of service to neighbor. There is an ongoing engagement in the task of correlating theology and pastoral care.
4. Pastoral care attempts to incorporate those who are cared for in the church as well as diverse faith groups. Pastoral care is a community endeavor. It seeks to bridge the gap between people and the gap between alienated individuals and God. Pastoral care's focus is on the individual, the couple, the family, and the community of faith.
5. Pastoral care is not performed only by the pastor. It is a task also for the laity. Taking seriously Luther's belief in the priesthood of all believers, pastoral care empowers the laity to strengthen the caring done by a congregation.
6. Pastoral care has a systemic and social orientation. Although pastoral care is not the same as social change, it is informed—as surely as any other aspect of the church's ministry—by an awareness of the need for social ethical action in specific situations.
7. When pastoral care calls for pastoral counseling, frequently in response to a crisis, that counseling normally is short-term. Ministers need to adopt a brief counseling orientation in their ministerial work, rather than rely upon the long-term perspective true of many in the mental health professions. In the few

situations when counseling must take longer, counselees usually are referred to other professionals or agencies within the community.

8. Pastoral care takes seriously the pastor's task and opportunity for initiation. It does not stand by waiting for people to request a counseling session. It takes the risk, once a problem is seen, of offering care even where help has not heen sought. It is proactive, not simply reactive, to expressed needs.
9. Pastoral care aims to help people to develop not only their feelings and attitudes, but also constructive behaviors and thinking. It recognizes that what a person feels and does greatly depends on what that individual thinks and believes.
10. Finally, pastoral care focuses on coping with contemporary here-and-now issues. Its focus is on the future rather than on extensive analysis of past history. Its orientation is preventive, centered on the strengthening of existing skills, abilities, and relationships rather than on breaking down or uncovering deep-seated problems or defects.

The model of care proposed here involves all four elements of the tradition of pastoral care. The future health of pastoral care and counseling itself depends on our recovering the historic balance and interaction between healing, sustaining, guiding, and reconciling.[22]

Pastoral care has benefited greatly by twentieth-century steps made in psychology. Unintentionally, though, it also has embraced some of the values and ideas of humanity—the "theologies" of modern psychology, thereby loosening its ties to Christian

[22] Christina M. Puchalski, "The Role of Spirituality in Health Care," Baylor University Medical Center Proceedings, Dallas, Texas, accessed October 28, 2015 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305900/.

theology. When pastoral care is faithful to its historical tradition, it is not theologically or morally neutral, as most psychotherapies claim to be, but seeks to help people grow in effective Christian living. When it is not, it is virtually indistinguishable, in philosophy and in function, from modern psychotherapeutic practice.[23]

This is the task of every Christian and the natural fruit of our redeemed life in Christ—to care for those who are near us. It is not only the responsibility of the ordained; the ministry of pastoral care for the neighbor is one in which all Christians are participants.

Several points are suggested here that can serve as a foundation for the pastoral care we offer.

1. Pastoral care is a task to which we have been charged; we are commanded to love others, no matter how difficult that might be. Although we love each other freely, spontaneously, and in gratitude to God for God's grace toward us, our Christian freedom does not allow us to sit down on the job.
2. Our ministry of loving and caring for others is based on our prior acceptance and love by God. All care for others flows out from God's love for us.
3. In this new relationship the old law is replaced by the law of love. Caring for God and neighbor becomes the criterion by which our actions are assessed.
4. One way to love God is to love one's neighbor. God would sooner have us invest our time and energy in serving our neighbor than in spending extensive time on acts of worship or scrupulous introspection. Service to our sisters and brothers is a central feature of our life "in Christ."

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[23] Howard W. Stone, *Theological Context for Pastoral Caregiving: Word in Deed* (Binghamton, NY: Haworth Press, 1996), 14.

5. The love and care we address to others is given to other Christians, to those who are not members of the Christian community whether Jew or Greek, and even our enemies. Pastoral care and counseling then is not only for the middle class who give to the church or pay for sessions; it is for all people.
6. Each member of the Christian community has a different configuration of gifts. All of us have a responsibility to use those particular talents that we have been given. We are not to covet others' gifts but rather enhance and use our own unique talents to their fullest extent.
7. Love of our neighbor is not just the correct attitude or the right belief. It is not simply knowing what to do or feeling affection and compassion. It is all of these, but it is also action—faith, active in love.

Love of God and our neighbor prompts our pastoral care ministry. We love God and neighbor when we respond to those in need who are around us. The love of God and neighbor is not only what serves to motivate the care that we as pastoral carers offer; it also should be a goal for the parishioner to strive for as well. One of the distinguishing marks of pastoral counseling should be that it tries not only to free up people from their problems, but also free them to love God and neighbor themselves. Therefore, love of God and neighbor is not only an objective for the ministering person but also an aim for those who are being helped.

Stone states that the primary thing that makes pastoral counseling distinctive is the outlook of the pastor. Ministers use different ways borrowed from secular psychology, but this one approaches them within a specific theological basis. Christian theology is

unique in its view on what it means to be human, its concept of health, and its understanding of human dilemma and deliverance. It often recognizes in the suffering person's words a different struggle and end point. This means that the warmth, openness, and acceptance of the pastor in any pastoral care relationship take on meaning surpassing the ordinary. A comprehensive theological viewpoint influences the essential foundation of pastoral care.[24]

Another difference between pastors and secular counselors originates from the point that pastoral care takes place within the context of the Christian community. The minister-parishioner encounter in a counseling chamber has as its larger setting the community of the church—a faith community. In fact, this context is not just a particular congregation at one point in time, but a long pastoral care tradition embracing the whole church and connecting the generations since at least the first century.[25]

Consequently, there is something different about pastoral care, and this "difference" means that the minister who responds to people from a Christian standpoint and within the context of the Christian community must have wrestled with and be working out a theology of such things as sexuality, marriage, reconciliation, health, and death.[26]

According to Stone, one distinctive aspect of pastors' care is their perspective, the way they relate theology and their own pastoral practice. There are a number of problems, though, inherent in this correlation of theology and pastoral care. Assuming we agree that

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[24] Howard W. Stone, *Theological Context for Pastoral Caregiving: Word in Deed* (Binghamton, NY: Haworth Press, 1996), 16-17.

[25] Howard W. Stone, 16-17.

[26] Howard W. Stone, 16-17.

such a correlation should occur, and aside from the methodological issues yet to be discussed as to how it can be done, some basic difficulties can hinder any such meeting and interaction. A familiarity with these difficulties alerts the caregiver to potential roadblocks that prevent the much needed dialogue.[27]

"The first area of confrontation involves the matter of ownership rights. Who owns the correlation enterprise? Which "side" gets to speak first—or last? Michael Taylor refers to this as disagreement over the game plan: Who serves first? What is in or out of bounds? How is it scored? What is the agenda? When there are differences, how do we go about settling them? What is the final authority? Scripture? Tradition? Experience? Relevance? Pastors probably remember from seminary days the tensions between the practical and classical fields. Those tensions, and the associated egos and politics, come into play when the two fields meet."[28]

"A second obstacle involves the question of which theology pastoral care is supposed to relate to. Should it be correlated with one of our historical theologies or a contemporary one? Which of the contemporary theologies—all of them, some of them, or only one? A denominational theology? There are so many voices, so many languages, so many historical periods of varying theological concern."[29]

"Pastors in the clinical setting have always developed a dialogical approach to theology that interfaced their *experience* with the body of *belief.* A general concern among supervisors about the character of the dialogue brought Paul Tillich to address the

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[27] Howard W. Stone, *Theological Context for Pastoral Caregiving: Word in Deed* (Binghamton, NY: Haworth Press, 1996), 16-17.

[28] Howard W. Stone, 16-17.

[29] Howard W. Stone, *Theological Context for Pastoral Caregiving: Word in Deed* (Binghamton, NY: Haworth Press, 1996), 18.

Fifth National Conference on Clinical Pastoral Education. Tillich was a natural selection among contemporary theologians because of his use of the "method of correlation" in which the questions implied in the Christian message. Pastoral care presupposes theology, he told the conference, but theology also presupposes pastoral care. Pastoral care helps to develop the questions to which religious symbols provide the answers. In specific acts of pastoral care, the human situation, to which the divine revelation is the answer, is seen most concretely and profoundly. Only in such correlations can religious symbols be understood and interpreted. This makes pastoral care genuine theological work."[30]

A different challenge in correlating theology and pastoral care has to do with the extreme complexity of the human beings who are the subjects of care. When we begin to relate theology and pastoral care encounter—we find that humans are very complex beings. No two caregivers would ever agree completely about given counselees—who they are, what their needs are, and what motivates their behavior. There are simply too many unknowns in our knowing, too many uncertainties about the individuals we seek to help, too much that is shrouded in mystery.[31]

However one more challenge: when correlating theology and pastoral care, which doctrines do we consider? It is Stone's impression that some doctrines of the church—anthropology, ministry, soteriology—relate quite readily to the types of situations we encounter in the day-in and day-out practice of pastoral ministry. Others, such as those that speak of the garden or the last things may seem distant and of little value. Which

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[30] David A. Steere, *The Supervision of Pastoral Care* (Eugene, OR: Wipf and Stock, 2002), 27.

[31] Howard W. Stone, *Theological Context for Pastoral Caregiving: Word in Deed* (Binghamton, NY: Haworth Press, 1996), 19.

doctrines are to take priority in the process of correlation? Which are to form the starting point of our theology?[32]

Gregg R. Allison in his book *Sojourners and Strangers: The Doctrine of the Church* "firmly maintains that the source—the sole source—and the starting point of our theology is Scripture, the Word of God."[33]

There is a way out of the chaos, disarrayed though it may seem. The requirement is that we be prepared to do the necessary spade-work, and reflect on our experience in light of the Word. In that way, theology can have an impact on our care. We may not, and probably cannot, resolve all the difficulties just enumerated, but we can be sensitive to them and hold them in tension as we proceed with the task of correlation. We can also recognize that what we finally come up with is likely to be very time- and situation-bound, perhaps applicable to only one specific individual or family, or at best to one particular community.[34]

For authentic correlation to occur, the pastor must return over and over again to the primary texts that shape the faith, read widely in theology and ethics, and have a continuing dialogue with the competing value and belief systems present in our culture.

Each person's correlation of pastoral care and theology will first involve a study of the sources of our faith and how they are expressed in theology, and secondly, a reflection on those sources as well as on our present experience with people entrusted to

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[32] Howard W. Stone, *Theological Context for Pastoral Caregiving: Word in Deed* (Binghamton, NY: Haworth Press, 1996), 19.

[33] Gregg R. Allison, *Sojourners and Strangers: The Doctrine of the Church* (Wheaton, IL: Crossway, 2012), 27.

[34] Howard W. Stone, *Theological Context for Pastoral Caregiving: Word in Deed* (Binghamton, NY: Haworth Press, 1996), 19-20.

our care and reflection on our relationship with God. Such reflection always is tied to the Christian community.

Even though no two will be exactly alike, pastors and ministers must develop a method of theological reflection that best suits their own needs. The method must be so simple that it can be intensely engaged and with use it becomes automatic, and yet so advanced that it takes seriously the complexity of individuals, values, and beliefs. In some situations we may indeed have time to think, consult, and devise appropriate pastoral strategies; we can, for example, probably consider at length a plan of treatment for someone who is chronically depressed. But in other situations, we may have to act reflexively, iu a way that is comparable to the "muscle memory" we employ while driving a car or playing softball. At such times, we must trust that the Word resides within us, that the faith is so ingrained in our living that it affects our decisions even when we do not have opportunity to think them through.[35]

No correlation is perfect and valid for every situation. Continual judgments must be made and acted upon, but these judgments and acts remain our frail attempts at truth. They are necessarily tentative; they must remain open to critique, to correction from the community, and to further insight. Nevertheless, pursuing truth to the best of our ability, real commitments must be made. It is at that poiut of commitment where reflection ends and the practice of pastoral care and counseling begins. Since at the point of action there is usually not enough time to go through a complicated procedure of correlating theology

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[35] Howard W. Stone, *Theological Context for Pastoral Caregiving: Word in Deed* (Binghamton, NY: Haworth Press, 1996), 16-17.

with pastoral care, a "trenches hermeneutics," and intuitive approach to the pastoral task, is required.[36]

Tillich believes that "Christian theology is designed to fulfill the demands of church. He states that, 'the method of correlation explains the contents of the Christian Faith through existential questions and theological answers in mutual interdependence.' This method summarizes Tillich's theological system. In this system, the philosopbical questions raised by analysis of human existence and the theological answers based on the sources, the medium, and the norm of the systematic theology must be divided and maintained. For Tillich, such a division underlies the structure of his theological system."[37]

Although one will frequently reflect on the care they offer, good correlation happens over and over again almost automatically in the way they listen and respond to another person's grief. Our faith, beliefs, and values shape what we say and do, as well as how we respond.

Finally, are laypersons considered pastoral caregivers? If so, that will change the character of the task as well. For the caregiver without a seminary education, there will need to be a method of correlation that is not as inordinately difficult or obscure as to be useless, yet not so simplistic as to avoid the complexities of the actual initiative.[38]

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[36] Howard W. Stone, *Theological Context for Pastoral Caregiving: Word in Deed* (Binghamton, NY: Haworth Press, 1996), 23.

[37] Paul Tillich, "Christian Theology," Boston Collaborative Encyclopedia of Western Theology, accessed October 30, 2015, http://people.bu.edu/wwildman/bce/tillich.htm.

[38] Howard W. Stone, *Theological Context for Pastoral Caregiving: Word in Deed* (Binghamton, NY: Haworth Press, 1996), 16-17.

The line between pastoral care and pastoral counseling is a lot blurred in the local church setting. Most pastors will be called on to fill both roles. For me, the distinction, perhaps false, is that pastoral care is expressed in every aspect of ministry, administration, preaching, and teaching. Pastoral counseling involves helping individuals and families explore pain and conflict at a level deep enough to design a new future through pain. It is a process that supports individuals' return to being in control, acting on their own behalf, when life seems to have thrown them off the road. Whether in pastoral care or pastoral counseling, as a pastor, one is likely to be faced with questions such as "What would you do, Pastor?" "What should I do, Pastor?" "What is the right thing here, Pastor?" These and many other questions can tempt us to step up to the role of expert in many areas for which we are not equipped. In caring or counseling the issue is not, "*What would the pastor do?"* or even *"What would Jesus do"?* but "*What does the person asking want to do, feel called to do, need to do with God's help?"* The pastor's task is to help the parishioner/counselee design his or her own solution. That is what the counseling process does. It helps a person sort out and designs his or her own solution.[39]

It is clear that congregations expect "presence" from their pastor. But many also expect "performance," meaning competence in key areas of ministry. In this study the focus is mainly on competence in counseling, brief counseling, and referral.

We define pastoral care as the general context for all ministries, including preaching, administering sacraments, and teaching, we can then add that pastoral counseling is a specific way in which to do pastoral care. This special way requires a core set of competencies. Performance is the end result of a composite of knowledge,

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[39] Larry E. Webb, *Crisis Counseling In The Congregation* (Nashville, TN: Abingdon Press, 2011), 21.

behavioral skills, attitude, and context. When all the pieces flow together in a transparent manner, those experiencing such competence are pleased and helped. So what are the pieces for the pastor?[40]

The pastoral counselor's toolbox needs a few essentials. It may, over time, contain much more, but it needs the essentials. These tools can be listed in three categories:

1. Knowledge
    a. Mental models to support understanding individuals, families, and groups.
    b. Knowledge of brief therapeutic processes usable within the short time frames available to a pastor.
    c. Information on more common mental and physical illnesses that assist the pastor in making effective referrals.
    d. Knowledge of crisis-oriented processes such as Critical Incident Debriefing.
2. Skills
    a. In-depth listening skills such as paraphrase, perception check, direct expression of feelings, fogging, behavior description, and negative inquiry.[41]
    b. Story listening skills to perceive the meaning in stories and to hear the spoken and unspoken messages.
    c. Special responses for handling strong emotions, criticism, and conflict.
3. Attitudes
    a. Peaceful in the midst of conflict.

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[40] Larry E. Webb, *Crisis Counseling In The Congregation* (Nashville, TN: Abingdon Press, 2011), 24-25.

[41] John Savage, *Listening and Caring Skills in Ministry: A Guide for Groups and Leaders* (Nashville, TN: Abingdon Press, 1996), 71-84.

b. Centered in the midst of crisis.

c. Affirming of others when criticized.

d. Appreciative, by finding what is working, good, and valuable in almost all situations.

e. Solution oriented rather than blame oriented.[42]

The most basic of all counseling skills is the ability to listen, in depth, to another person. By "in depth" I mean the ability to hear the meaning in the stories of another person; the ability to listen to pain without running away; and the ability to communicate to the other in a way that confirms you have heard the person as they want to be heard. We all have had the experience of feeling someone was listening but did not really hear us as we had hoped. And likewise, we have all listened, assumed we heard, and only later discovered that we had not at all understood what we had heard.[43]

The first step that a caregiver can take in seeking healing and justice for someone who is suffering is simple and natural: the caregiver listens to the care seeker's story.[44]

The fundamental that have been presented establish a collaboration between the theological principles of Contextual Theology, and Pastoral Theology and Counseling and helps to construct a theological foundation for the praxis and passion of the project;

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[42] Larry E. Webb, *Crisis Counseling In The Congregation* (Nashville, TN: Abingdon Press, 2011), 27-28.

[43] Larry E. Webb, *Crisis Counseling In The Congregation* (Nashville, TN: Abingdon Press, 2011), 29.

[44] Carrie Doehring, The Practice of Pastoral Care: A Postmodern Approach (Louisville, KY: Westminster John Knox Press, 2006), 15.

"Bringing Awareness to Faith-Based Leaders and Healthcare Professionals on Providing Emotional and Spiritual Support as Caregivers."

The first thing that makes pastoral counseling unique is the perspective of the pastor. Love of God and neighbor prompts our pastoral care ministry. We love God and neighbor when we respond to those in need who are around us. But love of God and neighbor is not only what serves to motivate the care that we as pastoral caregivers offer; it also should be a goal for the parishioner, faith-based leaders and healthcare professionals to strive for as well. One of the distinguishing marks of pastoral counseling should be that it tries not only to free up people from their problems, but also free them to love God and neighbor themselves. Therefore, love of God and neighbor is not only an objective for the ministering person but also an aim for those who are being helped.

Those who actually practice some form of spiritual ministry have more direct access to the primary subject of theological reflection on human nature than those who deal only with abstract concepts and constructs regarding persons. Summing up, some points are suggested that can serve as a foundation for the pastoral care we offer.

- Pastoral care is a task to which we have been charged; we are commanded to love others, no matter how difficult that might be.
- Our ministry of loving and caring for others is based on our prior acceptance and love by God. All care for others flows out from God's love for us.
- Caring for God and neighbor becomes the criterion by which our actions are assessed.
- Service to our sisters and brothers is a central feature of our life "in Christ."

The love and care we address to others is given to other Christians, to those who are not members of the Christian community "whether Jew or Greek," and even our enemies. Pastoral care and counseling is for all people. Love of neighbor is not just the correct attitude or the right belief. It is action—faith, active in love.

CHAPTER FIVE

THEORETICAL FOUNDATIONS

The primary concern is with education for pastoral care, with better ways of equipping the people of God for ministry within congregations, faith-based and healthcare institutions and communities; Bringing Awareness to Church, Faith-Based Leaders and Healthcare Professionals on Providing Emotional and Spiritual Support as Caregivers. While the main emphasis is upon the educational task, this pastoral caregiver wishes at this point to make clear his understanding of the nature of pastoral care and counseling as it relates to caregiving to which these endeavors are directed. At this point as we turn to a more systematic study of the theory and practice of equipping the aforementioned leaders to be effective caregivers, with the added advantage that we may refer to this material as we set out the theories which are central to our understanding of providing care as caregivers.

Edward P. Wimberly, author of *Moving from Shame to Self-Worth* states that people in congregational pews and people who come to counseling often have similar problems and needs. Traditionally, preaching has attempted to bring a perspective to human problems, a perspective that is grounded in a faith tradition, while counseling has sought to plumb the depths of a person's resources and relationships to find a cure for emotional, spiritual, and interpersonal problems. However, with the emergence of constructive theory and a hermeneutical understanding of the meaning-making process,

there is some overlap of the functions of preaching and counseling. Though the settings are different, both preaching and pastoral counseling function to help people bring meaning to their experience.[1]

Pastoral care is viewed here as an extension far beyond the work of the clergy; in the life of the local congregation, pastoral care comprises the assisting and support offered by many lay people who share in the visitation of the elderly and sick, and in countless acts of human care and concern which nced no label. For a hospital chaplain, pastoral care involves both the systematic visiting of units and the brief bedside visits to patients and their families in a time of crisis, as well as the more extended counseling of patients who are specially referred.

Some biblical foundations has already been laid as it relates to providing spiritual support to the caregiver as well as the one being cared for. He has also noted in his historical foundation, ideas about the main goal of pastoral care as it relates to caregiving have varied from one era to another. We have also been made aware of the pastoral care which has been dominant until recent times, that of the 'minister in his or her parish' exercising a somewhat authoritarian pastoral oversight of their flock.

New books are continuously interjected in the class rooms of Clinical Pastoral Education and the movement in the seventies and eighties and nineties were fed by an abundance of new therapies. Gestalt psychology is just one approach used to enhance therapy. The new movement has been blessed to have many new generations of CPE trained teachers of pastoral care who brought in-depth psychology and clinical methods to the forefront.

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[1] Edward P. Wimberly, *Moving From Shame to Self-Worth: Preaching and Pastoral Care* (Nashville, TN: Abingdon Press, 1999), 16.

In terms of the future of pastoral counseling, it is evident that this form of counseling will be around for many years to come. As it raises awareness, it will also be taking a new stance as far as technology is concerned. The wave of the future has presented the need to be televised, computerized, and even recorded on CD for classroom use. It is a spiritual healing for the brokenness that we all, as children of God, have or will experience as we continue on this journey of life.

The intention is not to diminish previous approaches to pastoral ministry, for each has had its own validity in its particular historical and social context. It should not surprise us, however, if the pastoral care relevant to the late twentieth century has its own kinds of expression and self-understanding. On the contrary, we should expect that while these have a contemporary relevance, the pastoral care appropriate to a future generation will take a different form. Our current concern, however, is with the forms of pastoral care which seem to be relevant today or in the immediate future.

Pastoral care has frequently been perceived as a helping response to the crises of life, and so it is. Those with any experience of ministry will have spent much time and energy supporting people who are shattered by bereavement, or worried by the onset of illness. All this is taken for granted. A pastoral ministry which does not respond with compassion to those human crises is a contradiction in expressions. Yet an understanding of pastoral care which sees itself solely in these terms is impoverished and unreliable. We may presume that while Jesus left the uinety-nine in the sheepfold to go in search of sheep that was lost, his concern for the lost sheep did not imply any abandoning of his commitment to the long-term welfare of the rest of the flock. When the lost sheep had

been found, no doubt the good shepherd returned to the routine work of tending the whole flock (Luke 15:3-7).

Pastoral counseling, therefore, is an important specialist ministry of the church and the great contribution which such specialist ministries make to helping people in need cannot be denied. The approach to pastoral education, however, rests upon the conviction that pastoral care has its own integrity. It is necessary, therefore, to clarify further the differences between pastoral care and pastoral counseling, not least in order to safeguard the integrity of each. Pastoral care as understood in the context of the present discussion covers a very broad canvas. It encompasses much, but not all, of the everyday work of a minister in the midst of a congregation and parish; it includes visits to a newly-bereaved family and follow-up visits after the funeral, visits to members of the congregation in the hospital, and to the elderly in nursing homes as well as the homebound. It takes in the apparently casual encounters with worshippers after services.

The aim is to affirm a theology and practice of ministry which does not see the ordained ministry as exercising a kind of pastoral care different in nature and isolated from the ministry of the whole people of God. Yet at the same time it recognizes the distinctive contribution of an ordained and/or commissioned ministry within the life of the church. There is one ministry shared by 'ministry' and 'laity'. Neither must be devalued at the expense of the other for they are of interrelated and interdependent. There are important and distinctive ministries, which are integral to the Christian vocation of many people within the Church, and are exercised by elders, lay leaders, class leaders and countless others in congregational and community life and work situations. To be aware

of individual ministries within the congregation, each with its own distinctive function is not to devaluate any of them but to affirm their richness in diversity.

Those who seek to care for others seldom fail to receive something in return, even if it is no more than the satisfaction of having tried to help another in a time of need. The 'need to be needed' is a characteristic of many, if not all, who seek to care for others. No one who has been involved in ministry for any length of time can fail to be aware of situations where having gone to offer help; one comes away strengthened by the faith and courage of the person supposedly in need of care.

It must be recognized and affirmed that both care for the individual and social action have a central place in the life and mission of the church.

"The ministry of care requires a theory of personhood if it is to effectively increase the welfare of individuals and their communities. Indeed, it is difficult to expand love of self if one does not have some idea what the self is and how it is shaped. Drawing upon philosophical concepts based in process theology, and psycho-systemically oriented pastoral theology interprets the human individual as a network of relationships. As the network of relationships expands, the self is enriched and increases its ability to contribute to its own life as well as to the life of the world."[2]

"The self is looked upon as a sense of values that is brought about and sustained by the relationships of self with the world the self dwells. Persons who are well often have little need to talk about their bodies but for the sick person who has received sense of self and the perspectives of whose world are often radically called into question by

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[2] Larry Kent Graham, *Care of Persons, Care of Worlds: A Psychosystems Approach to Pastoral Care and Counseling* (Nashville, TN: Abingdon Press, 1992), 70.

their illness and for whom the world and their place within it is subject to re-interpretation, it is critical. Such interpersonal storytelling is fundamental in establishing identity, both personal and social, and in facilitating healing by bringing order out of the chaos of illness."[3]

Therefore, learning to listen to the narrative of the body and learning genuinely to 'hear' what the bodies of sick people are saying in the total ecology of treatment and therefore accepting its causes outside of self, is the starting point of building spiritual care. This the case as much as it is the practice of narrative medicine and the one has the ability to inform and improve the other in the search for healing and wholeness. Being dialogically relational not only forms the basis of care in practice but is key in our understanding of the way in which human persouality, or personhood, is built and understood.[4]

Larry Kent Graham in his book *Care of Persons, Care of Worlds* emphasizes that "A psychology of ill health or disability must consist of an understanding of the psychological and social impact of disability on the person who is incapacitated, the family, and others in relationship with the person with a disability. An understanding of the psychological frame of mind, and attitudes of individuals and society toward disability is also needed. Accurate empathy is essential to the understanding, support, and treatment of persons with a disability. Empathic understanding implies that the therapist is able to sense the client's feelings as if they were his or her own, without becoming lost

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[3] Pye, Jonathan, Peter Sedgwick and Andrew Todd, eds., *Delivering Care in Healthcare Contexts* (London, UK: Jessica Kingsley Publishers, 2015), 17.

[4] Pye, Jonathan, Peter Sedgwick and Andrew Todd, eds., 17.

and overwhelmed in those feelings. Empathy is not objective knowledge about the client; it 'is a deep and subjective understanding of the client with the client.' Two essential aspects of empathy are intellectual identification of oneself with another through knowledge and understanding and emotional identification of oneself with another, through the ability to feel with another."[5]

In recent decades there has been a dramatic rediscovery of a striking reality—all Christians are called to minister because they are Christians, whether or not they are ordained. People's individual missions are as unique as their fingerprints, reflecting the special interests, values, and gifts of each individual. Awareness that they have their own special religious vocation or calling gives laypeople new empowered self-images. They have a vital and unique ministry within congregations and in the wider community and world beyond their church—to their neighbors, theirs business associates, their union, their friends, their enemies, and especially the disadvantaged, rejected, and exploited people in their community. The vitality of the ministry of the laity may be reaching a level that has not existed since the early decades of the Christian movement. The potentiality of this development is almost unlimited. A growing group of laypeople of many ages and backgrounds is responding to the invitation of God's exciting call.[6]

The caring ministry of laypeople is essentially an outreach ministry to persons in need within the congregation but also in the wider community, including their families, friends, and work colleagues.

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[5] G. P. Nagel, *Disability* David G. Benner and Peter C. Hill, eds. *Baker Encyclopedia of Psychology and Counseling* (Grand Rapids, MI: Baker Books, 1999).

[6] Howard Clinebell, *Basic Types of Pastoral Care & Counseling: Resources for the Ministry of Healing and Growth* (Nashville, TN: Abingdon Press, 2011), 441.

In this context, what is the function of clergy? By virtue of training and ordination, clergy are equipped and designated to function as leaders, trainers, and specialists in what is the work of every Christian. The key role of clergypersons, as described in Paul's letter to the early church in Ephesus, is 'to equip God's people for work and service' (Eph. 4:12), the job of clergy is to train, inspire, guide, coach, and work alongside lay ministers as teachers of teachers, pastors of pastors, and counselors of counselors.[7]

Faith-based leaders can be viewed in two ways: as workers to fill leadership slots or as fellow ministers who need special pastoral care corresponding with their added responsibilities. Of course, the latter is the choice. But this pastoral care is not the job only of the senior pastor. Faith-based and church leaders; lay and clergy can learn to pastor each other. After all, we need one another, not just to perform ministry, but to serve as mothers, fathers, sisters, and brothers to each other through the body of Christ.

Perhaps the best reason for addressing spiritual aspects of illness is that so many of our patients are religious and have spiritual needs. Being spiritual is part of who many people are—it forms the origins of their identity as human beings and gives life meaning and purpose. Spiritual needs become particularly pressing at times when medical illness threatens life or way of life. Not only is religion vital to the identities of many people, it is often used to cope with troubling life circumstances—especially sickness and disease.[8] Religious coping is the use of religious beliefs or practices to reduce the emotional distress caused by loss or change. Patients may "turn over" their problems to God, trusting God to handle them so that they do not have to contemplate or worry about them.

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[7] Howard Clinebell, *Basic Types of Pastoral Care & Counseling: Resources for the Ministry of Healing and Growth* (Nashville, TN: Abingdon Press, 2011), 444.

[8] Harold G. Koenig, *Spirituality In Patient Care: Why, How, When, and What* (Philadelphia, PA: Templeton Foundation Press, 2002), 6.

People suffer everywhere, every day, in settings as dramatic as racial, political or cultural conflict or as commonplace as a suburban household. In their pain they inevitably raise questions about God's role in the sometimes painful and even horrifying affairs of human life. These questions concern the issue of theodicy; that is, the attempt to explain how the power and goodness of God can be reconciled with the experience of evil.[9]

How do we care for a grieving person who asks, Why did God let this happen? How could God allow someone so young to die? Where is God in this plane wreck? First, we must discern the true nature of the question. Many whys are poetic questions. symbolic ways to express the depth of one's misery. It may be easier to ask why did God do this? Than to say I feel devastated by my loss. It certainly is a mistake to engage in theological discussion when the person's question is not a question but a metaphoric way of expressing powerful emotions.

Caregivers have to prepare themselves to respond to suffering and to the theodicy questions of those who suffer. Vital to that preparation is a thorough, personal examination of theodicy in light of one's own faith. Whether helpers respond to the vital issues of theodicy, neighbors and friends are likely to do so. One-dimensional and damaging answers flow from well-meaning individuals at a time when their hearers are vulnerable. Many suffering people are left off balance by theological answers such as, "this in essence has happened to bring her to the Lord," or "God wanted her to be with Him in heaven." They may also hear simple psychological answers to the theodicy issue. One answer may be that "you are responsible for your feelings," or "you are sick because

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[9] Theodicy: An Overview, accessed October 26, 2015,http://www3.dbu.edu/mitchell/theodicy.htm.

of your destructive thoughts." Thoughtful guidance by the helper can help prevent or heal the hurts brought on by such misguided truisms.[10]

It is also important to remember that many people who do not verbalize about theodicy questions are thinking about them just the same. The whys come up from the deepest well of one's being and should not be turned into casual ideological debate. Caregivers who have worked out their own views on theodicy will recognize the uniqueness of each person and each situation and frame their responses accordingly. Our task is to help suffering people find their own metaphors that convey the comfort and promise of our faith.[11]

When we talk with persons about their understandings of suffering, it is best to begin by learning their thoughts (however uncertain) rather than immediately verbalizing our own views, listening very carefully before responding. Sometimes it is helpful to ask direct questions: Is that how you have always thought about it? What is troubling or confusing you now? What answers have other people suggested to you? How has this loss (illness/divorce) affected your faith?

We need to be careful not to imply that those who are suffering ought to feel any particular way. People who already feel guilty for questioning the goodness of God may end up feeling doubly guilty if the caregiver declares, for example, that one should view suffering as a blessing.

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[10] Theodicy: An Overview, accessed October 26, 2015, http://www3.dbu.edu/mitchell/theodicy.htm.

[11] Theodicy: An Overview, accessed October 26, 2015, http://www3.dbu.edu/mitchell/theodicy.htm.

When communicating our own understanding of faith's response to theodicy in a care or counseling setting, we are not engaging in a technical theological discussion. It is important to speak personally and directly, without jargon, yet give suffering people the cognitive tools they need to begin making sense of their plight. Possibly the most helpful approach is to speak from our own experience of loss and our own struggle with the question of theodicy, sharing what has benefited us or others we know in times of pain. We also can share the message of Scripture—not citing isolated texts to prove a point but emphasizing its many stories of God's abiding presence and help in times of trouble.[12]

Suffering is not a thing to be desired. It is a given—not good but inevitable, a part of our finitude that can lead to growth or despair. It may be that more people will survive the experience of evil, loss, and pain with the help of a believer's quiet assurance and the presence of God than with a religionist's critique of their theology. But in the midst of suffering God speaks both a verbal (literal) Word through the clear discussion of why questions and a visible (metaphoric) Word through the loving presence of the church embodied in the pastoral ministry of another.[13]

Wimberly writes to the leaders of the church proclaiming a need to look at themselves before counseling others. He empowers the reader to face the shames and ultimately gaining self-worth that courageously strengthening one to be more self-sufficient. The quest propelled the reader in such a way to search out ways to get church

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[12] Theodicy: An Overview, accessed October 26, 2015, http://www3.dbu.edu/mitchell/theodicy.htm.

[13] Stone H., D. G. Benner and P. C. Hill, eds. *Suffering. Baker Encyclopedia of Psychology and Counseling* (Grand Rapids, MI: Baker Books, 1999).

leaders motivated to search their own philosophy of life and death. The end result will enable church leaders to be present without any reserves when it comes to staying connected with those suffering in the end of life crisis.[14] And it is with hope that this would initially begin the process to equip them in providing emotional and spiritual support to caregivers.

Carrie Doehring in her book *The Practice of Pastoral Care: A Postmodern Approach,* states that "empathy plays a vital role in pastoral care. It is a means of creatively stepping into the shoes of another person and seeing the world from her or his perspective. However, at the same time they make this connection, it is essential that caregivers keep their own perspective and be aware of what is taking place within both themselves and the caring relationship. Empathy involves two simultaneous and opposite relational skills: *First*, making connection with another person by experiencing what it is like to be that person. And *secondly*, maintaining separation from the other person by being aware of one's own feelings and thoughts. Empathy is a balancing act."[15]

To care for another person, one must be able to understand them and their world as if one were inside it. One must be able to see, as it is, with his or her eyes what their world is like to them and how they see themselves. Instead of merely looking at them in a disconnected way from outside, as if they are some case to be shunned or rejected. One must be able to be with them in their world, "going" into their world in order to sense from "inside" what life is like for them, what they are striving to be, and what he or she requires to grow or mature. But only because one understands and responds to their own

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[14] Edward P. Wimberly, *Moving From Shame to Self-Worth: Preaching and Pastoral Care* (Nashville, TN, Abingdon Press, 1999), 21.

[15] Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach* (Louisville, KY: Westminster John Knox Press, 2006), 18.

needs to grow can understand the striving to grow in others. One can understand in another only what he or she can understand in him or herself.

In being with the other, one does not lose themselves. They retain their own identity and are aware of their own reactions to them and their world. Seeing their world as it appears to them does not mean having their reactions to it, and therefore one is able to help them in their world: something they are unable to do for themselves. One does not have to be perplexed, but because one "feel" others perplexity from inside, one may be in a position to help him or her out of it. Such understanding is open to inquiry and examination, and is a matter of one's ongoing development through new experiences and information.

Jeffrey D. Hamilton, D. Min. takes a holistic approach iu his book, *Gestalt in Pastoral Care and Counseling*. Gestalt is a way of understanding relationships and change that validates experience in the here and now, as well as a person's history aud life experience.[16] The here and now theory, Gestalt, is to make the client and the therapist aware of the moment. Great value comes out of the fact that a therapist can relate to a client as he or she talks with them about experiences similar to theirs. However there should be boundaries set between the therapist and the client. The focus should be the here and now. It does not matter what went on in the past. The here and uow raises awareness and helps to promote action to make clear decisions. As counseling sessions move forward the focus in the relationship is characterized by participation with others iu their struggle to remain whole with clear identity. The relationship is grouuded in the

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[16] Jeffery D. Hamilton, *Gestalt in Pastoral Care and Counseling: A Holistic Approach* (Binghamton, NY: Haworth Press, 1997), 4.

affirmation of a person's worth in being a member of God's world, highlighted by his or her desire and work to gain self-understanding.[17]

The importance of a human being is established by God, not by people. This fact rests at the core of every ethical debate that is created by the advancement of medical technology. It is essential that we do not underestimate the truth that "men and women, in their very nature, reflect something of the dignity and worth of God." Our view of God determines how we view and treat each other and ourselves. God's love and concern for each of us does not fail because we are weak, less intelligent, sick, and dying and, therefore, neither should ours. Among the greatest and most successful people in our land are nurses and volunteers who have chosen to care for the dying—to respect and care for those who suffer. These caregivers have not forgotten the inherent significance of a human being.[18]

How can we say that we respect the weak and the dying when more than three-quarters of those who die do so in hospitals and federal programs? They are disregarded by a fast-paced American economy that has little time for those who cannot keep up. They attended our churches and supported our economy with their strength and talents, but when they grew weak and fragile, churches and businesses all too often focused on their younger and stronger replacements without ensuring that care would be provided to those who had gone before. Everyone in society has put the brunt of the financial

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[17] Jeffery D. Hamilton, *Gestalt in Pastoral Care and Counseling: A Holistic Approach* (Binghamton, NY: Haworth Press, 1997), 5.

[18] Stewart, Gary P., William R. Cutrer, Timothy J. Demy, Donal P. O'Mathúna, Paige C. Cunningham, John F. Kilner and Linda K. Bevington, *Basic Questions on End of Life Decisions: How Do We Know What's Right?* (Grand Rapids: Krege Publications, 1998), 28-53.

responsibility on the shoulders of the government. Although the government is helping and should continue to do so, the church and the business world have a financial responsibility (debt) to support hospice care or create facilities of their own to meet the needs of America's aging elders.[19]

King David asked God not to cast him off "in the time of old age" and not to forsake him when his strength failed—an allusion to all-to-common behavior toward the elderly and the weak (Psalm 71:9). We, the people of God, who are the image-bearers of God, are responsible to ensure that the dignity and concerns of the weak and aging do not go unnoticed and unresolved. To ignore, cheapen or dishonor those who become weak among us is a form of oppression; and to claim that we are a people of God, demands that we do justice and righteousness by pleading "the cause of the afflicted and needy" (Jeremiah 22:15-17). God has taken his place in the divine council in the midst of the gods he holds judgment. "How long will you judge unjustly and show partiality to the wicked? Give justice to the weak and the orphan; maintain the right of the lowly and the destitute. Rescue the weak and the needy; deliver them from the hand of the wicked." (Psalm 82:1-4). In other words, your dignity is established by God and placed under the protection of society. Your age, ability, and medical status do not affect your intrinsic dignity.[20]

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[19] Stewart, Gary P., William R. Cutrer, Timothy J. Demy, Donal P. O'Mathúna, Paige C. Cunningham, John F. Kilner and Linda K. Bevington, *Basic Questions on End of Life Decisions: How Do We Know What's Right?* (Grand Rapids: Krege Publications, 1998), 28-53.

[20] Stewart, Gary P., William R. Cutrer, Timothy J. Demy, Donal P. O'Mathúna, Paige C. Cunningham, John F. Kilner and Linda K. Bevington, 28-53.

CHAPTER SIX

PROJECT ANALYSIS

The hypothesis of this project suggests that individuals who are in home, hospital or hospice care needs care from equipped and trained caregivers in faith-based and healthcare institutions. The research reveals the reality that faith-based leaders and healthcare professionals are not equipped to minister to provide emotional and spiritual support as caregivers. Furthermore, based on the research, faith-based leaders and healthcare professionals feel inadequate when providing caregiving for individuals who need care. The patient faces many new challenges. As the caregiver one can help the patient deal with these challenges and get through any problem that may arise. The best way to prioritize and manage problems is to first try to understand the problem as well as the desired result. Caregivers who are realistic, but positive; careful, but creative; and focused, but flexible are sources of strength and security for people who need the care of a caregiver.

This chapter will present the project objectives, the collection of data, the data analysis, and the outcomes. It will give details of information shared, new findings, and the participants' reactions during the three workshop sessions. The information within this chapter will present the reader with a thorough understanding and findings of the session's happenings. The sessions brought awareness of the importance of caregiving training which gave participants permission to discuss their personal experiences with

caregiving. By bringing awareness to faith-based leaders and healthcare professionals on providing emotional and spiritual support as caregivers, leaders will become enlightened on the importance of setting up future sessions in their own ministries or institutions necessary for individuals who need caregiver training.

The research project was held in December 2015 and January 2016. All three sessions were held at Houston Methodist Hospital (HMH), 6565 Fannin; Houston, Texas. The sessions were implemented by the facilitator, and attended by twenty-six individnals who volunteered to participate in the project. The population participants consisted of pastors, nurse directors, registered nurses, Patient Care Assistants (PCA), Case Managers, Social Workers, chaplains, and lay volunteers and other healthcare staff.

Regular meetings and communications were held with the professional and contextual associates and peer associate, utilizing conference calls, emails and when possible face to face meetings. The contextual associate reviewed the project proposal and gave support to the design of the project. The contextual associate was also involved with the dissemination and review of data obtained from questionnaires, surveys and training. He was involved in each step of the evaluation process. All peer groups gave critical and supportive feedback to the research project.

The research project utilized a qualitative research approach. The target audience for this project was faith-based leaders and healthcare professionals. The project utilized targeted persons amongst the leaders and professionals. The research project took place over a three day period totaling three workshops. Each leader was interviewed with pretest and posttest questions before and after the workshop. Data from the pretest and post-test questionnaires was compiled.

Proposed Project Implementation; Two Workshop Series:

Workshops 1: Educate

Pretest Questionnaire

Welcome/Statement of Purpose:

Purpose: Bringing Awareness to Faith-Based Leaders and Healthcare Professionals on Providing Emotional and Spiritual Support as Caregivers

Presentation:

Workshop 2: Equip

Welcome/Restatement of Purpose:

Roundtable discussion:

Closing:

Administer Posttest Questionnaire

Follow up work:

Follow up work on this project included interpretation of data collected, follow-up interviews as needed, and other activities to complete the project. The results from interviews were reviewed for validity. The goal of this project was to educate and bring awareness to faith-based and healthcare leaders with the "tools" to increase their self-care and confidence to handle difficult situations, emotions, and decisions when it comes to providing emotional and spiritual support as caregivers.

Focus Group Sessions

Session 1: Workshop

1. Introduction

The participants completed a pretest questionnaire consisting of twelve questions relating to caregiving. The data was used as an evaluation tool to determine the outcomes of the workshop sessions. A presentation was given to the population participants. A posttest questionnaire was given with the same questions after the presentation.

The effectiveness of the project was measured by comparing and analyzing the information obtained from pretest and posttest questionnaires, focus groups, and surveys which documented the outcomes of each session.

Histograms were used for Pretest Questions 1, 2, 3, 5, 8, 9 and 11in order to show the number of times or the frequency in which an answer option was chosen by the population participants.

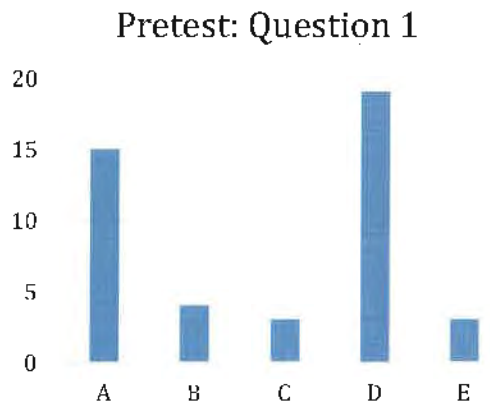
The questions in the questionnaire was given to a total twenty-six faith-based leaders and healthcare professionals in three workshops in order to gain insight into what the participants experiences had been in caregiving. The population participants consisted of pastors, nurse directors, nurse managers, registered nurses, Case Managers, PCAs, chaplains, and lay leaders. The questions, response options, and graphics below will give some insight into the pre-established ideas the participants had about caregiving.

Pretest Question 1 is "What is your definition of caregiver?" The results are as follows:

Pretest Question 1

Table 1a

A	15
B	4
C	3
D	19
E	3



Posttest Question 1

Table 1b

A	16
B	4
C	6
D	19
E	2

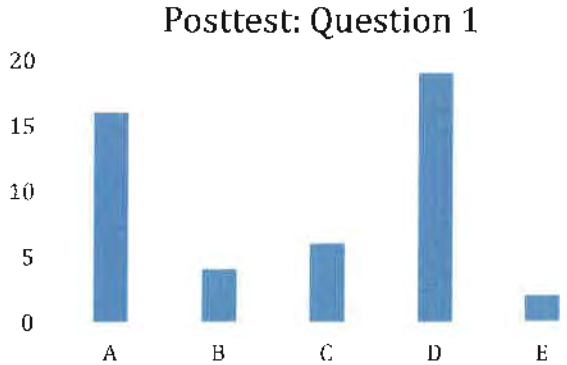


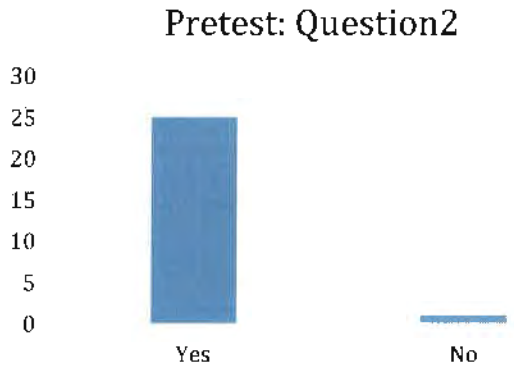
Table 1a shows a range of participants' responses to the multiple choice answers "a thru e" for Pretest Question 1. Fifteen selected option "a" that a caregiver is a person who offers help and protection. Four selected option "b" that a caregiver is a person who visits a sick family member once a month. Three selected option "c" that a caregiver is one who sends money to help someone in need. Nineteen believed that a caregiver is a person who provides direct care to a loved one, and three selected option "e" indicating that they had their own definition of a caregiver.

However Posttest Question 1, Table 1b shows a complete different range of responses. There was a slight change for option "a," sixteen thinks that a caregiver is a person who offers help and protection. Four selected option "b" that a caregiver is a person who visits a sick family member once a month. For option "c" three more, making a total of six selected this answer option which states that a caregiver is one who sends money to help someone in need. Nineteen believed that a caregiver is a person who provides direct care to a loved one. And for option "e" only two had their own definition of a caregiver after the workshop.

Pretest Question 2

Table 2a

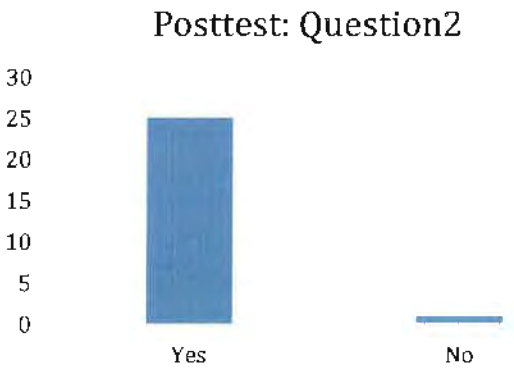
Yes	25
No	1



Posttest Question 2

Table 2b

Yes	25
No	1



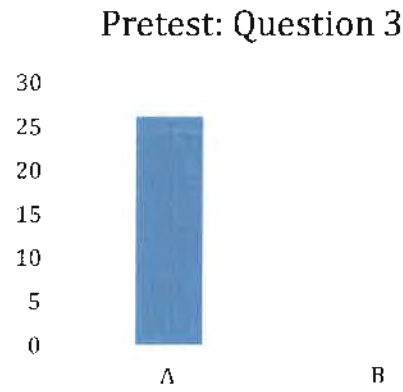
The Pretest and Posttest Question 2, was a yes or no question which asks, "Are you or have you ever been a caregiver?" For both test there were no changes. There were

twenty-five "yes" responses for Pretest Table 2a and Posttest Table 2b, and there were one "no" answer for Table 2a and 2b.

Pretest Question 3

Table 3a

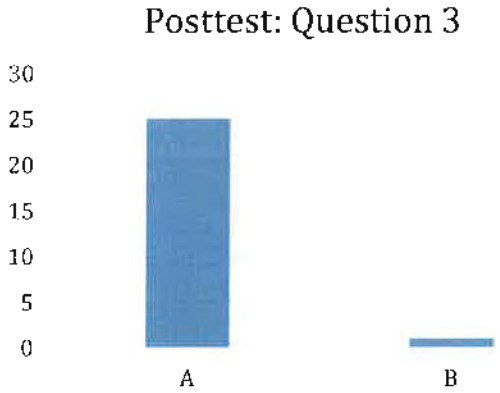
A	26
B	0



Posttest Question 3

Table 3b

A	25
B	1

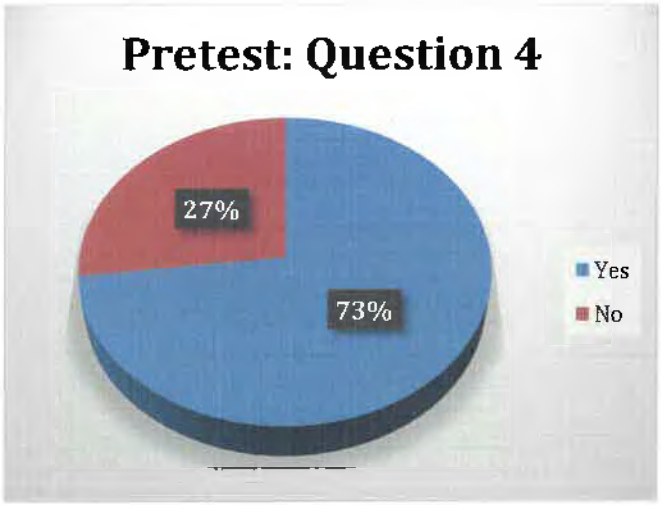


The pretest and posttest Question 3 asks the question, "How do you feel about being a caregiver?" With option "a" as being a positive experience and option "b" being a negative experience. There were twenty-six responses for option "a" for Pretest Question 3, Table 3a and there were no selections for "b". For Posttest Question 3 Table 3b there were twenty-five responses for option "a," and there were one response for option "b". For future directions in terms of equipping, I will focus my training in a direction that helps equip those who have had a negative experience in order to hring about a positive experience.

Pretest Question 4

Table 4a

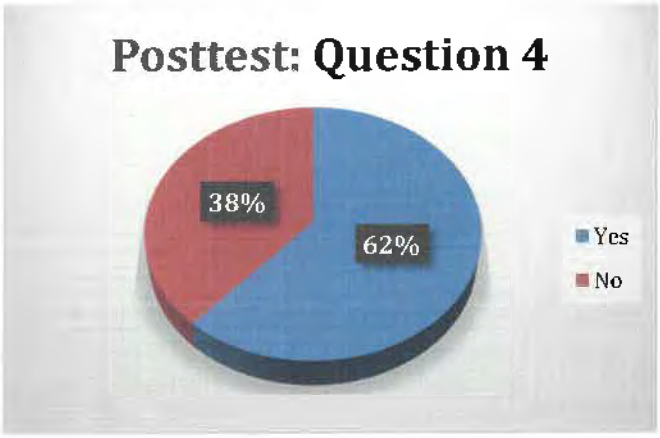
Yes	19
No	7



Posttest Question 4

Table 4b

Yes	16
No	10

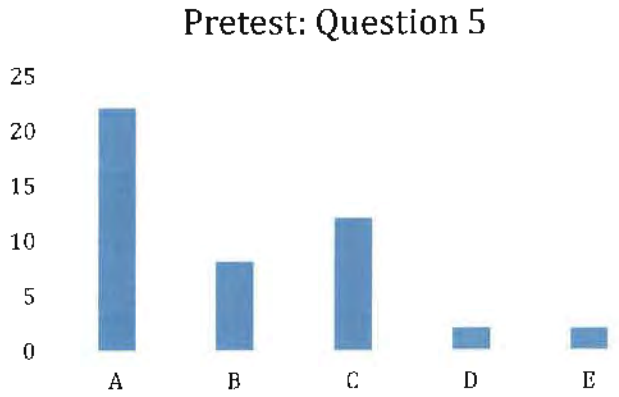


Pretest Question 4 and Posttest Question 4 ask: "Have you ever had training to be a caregiver? If so, what kind?" If the participant selected responded with "yes," then they were asked, "If so, what kind of training?" The second option was "no." Seventy-three percent of the participants in Table 4a reported that they had training to be a caregiver. Their written responses for what kind of training varied. Twenty-seven percent answered "no" in Table 4a that they had no training in caregiving. In Posttest Question 4 Table 4b, the responses were sliced to sixty-two percent that said "yes,"—they had training to be a caregiver. And the percentage increased to thirty-eight percent that said they had no training to be a caregiver. That informs me and validates my point that faith-based leaders and healthcare professionals need training and additional training when it comes to caregiving.

Pretest Question 5

Table 5a

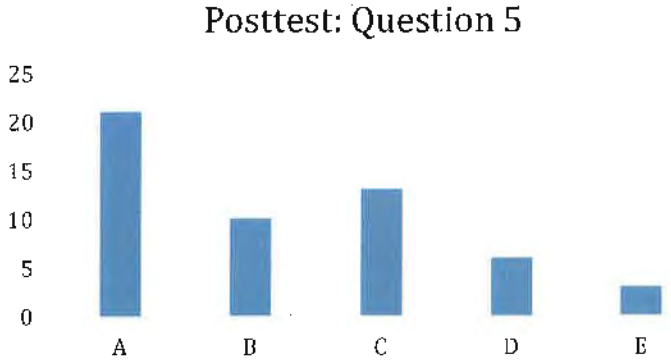
A	22
B	8
C	12
D	2
E	2



Posttest Question 5

Table 5b

A	21
B	10
C	13
D	6
E	3



Pretest Question5 Table 5a shows a range of participants' responses to the multiple choice answers a-e, to the question "What are some difficulties that you have faced as a caregiver?" Twenty-two selected option "a" that emotional and mental stress was a difficulty they had faced as a caregiver. Eight selected option "b," that burnout was a difficulty that they had faced. Twelve selected option "c" that a lack of time for self-care was a difficulty they had faced. Two selected option "d" that they were angry for being pushed into the role of caregiving as a difficulty they had faced, and two selected option "e" that the question did not apply to them.

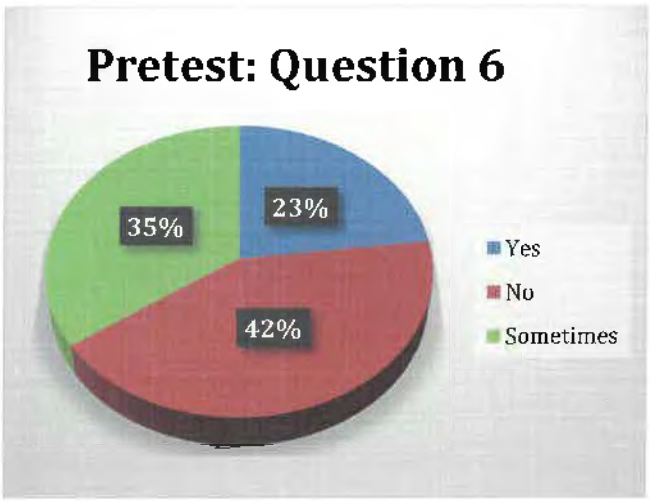
However Posttest Question 5, Table 5b shows a very different response. Twenty-one selected option "a," that emotional and mental stress was a difficulty they had faced as a caregiver. Ten selected option "b," that burnout was a difficulty that they had faced. Thirteen selected option "c" that a lack of time for self-care was a difficulty they had faced. Six selected option "d" that they were anger for being pushed into the role of caregiving as a difficulty they had faced, and three selected option "e."

For future directions in terms of equipping caregivers, I will focus on option "a" because more people struggle with emotional and mental stress when it comes to caregiving. Unfortunately, stress among caregivers is extremely common. Caregivers often try to do everything by themselves, which eventually leaves them worn out and unable to fully attend to everything they are expected to do. Furthermore, ignoring the symptoms of stress can affect physical and mental health and lead to burnout, and make it impossible for the caregiver to continue caring for their loved one.

Pretest Question 6

Table 6a

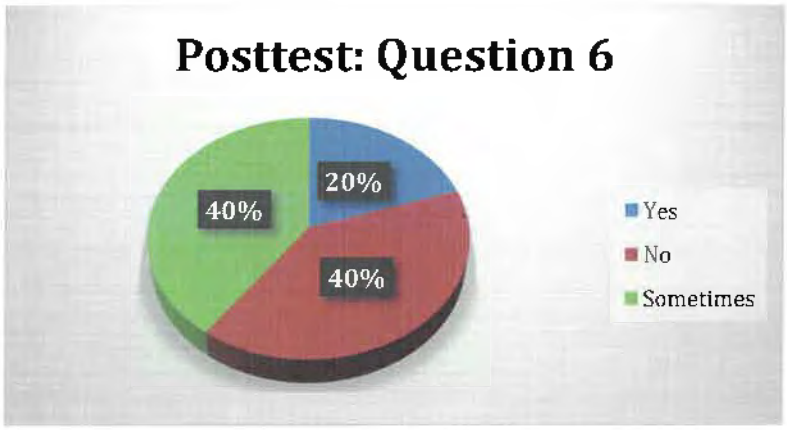
Yes	6
No	11
Sometimes	9



Posttest Question 6

Table 6b

Yes	5
No	13
Sometimes	8

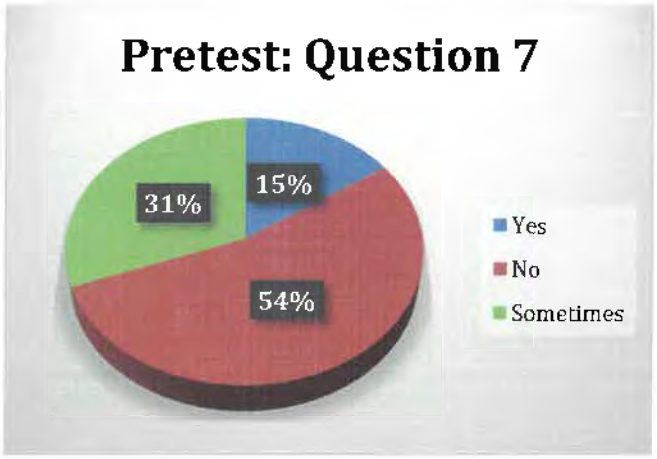


Pretest Question 6 asks, "Are you resentful when other family members are not helping?" Twenty-three percent of the participants answered "yes" for Pretest Table 6a. Forty-two percent of the participants' response was "no" and thirty-five percent responded "sometimes." After the presentation there were some changes in response to the question, for Posttest Question 6 Table 6b twenty-percent responded "yes." Forty percent responded "no" and forty percent responded "sometimes."

Pretest Question 7

Table 7a

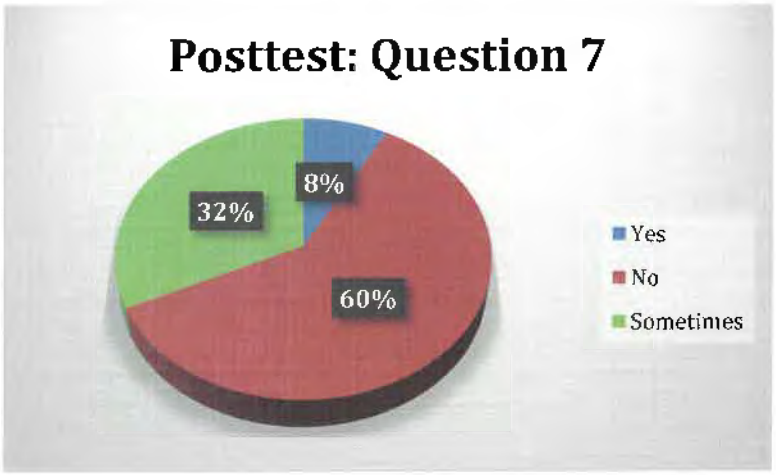
Yes	4
No	14
Sometimes	8



Posttest Question 7

Table 7b

Yes	2
No	15
Sometimes	8



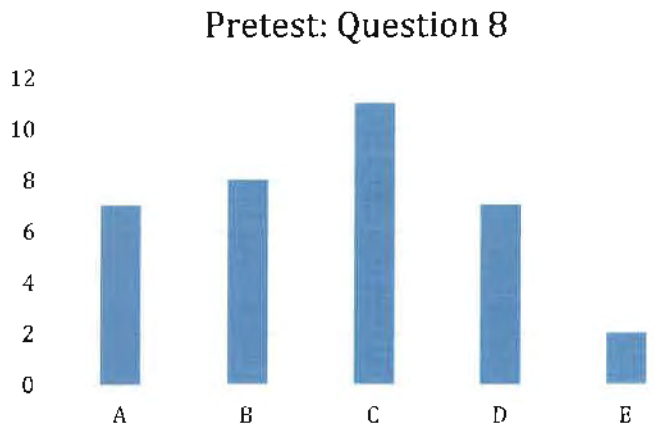
Question 7, asks, "Do you feel trapped by all the responsibilities as a caregiver?" In the Pretest, fifteen percent of the participants answered "yes" as indicated in Table 7a. Fifty-four percent of the participants' response was "no" and thirty-one percent responded "sometimes." However on the other hand the percentages changed for Posttest Question7 Table 7b where the participants who responded "yes" to the question dropped to eight percent. The responses for "no" increase to sixty percent and a slight change of thirty-two percent responded "sometimes."

After the workshop, fewer participants felt maybe their understanding of what it means to be trapped as caregivers changed as a result of the workshop.

Pretest Question 8

Table 8a

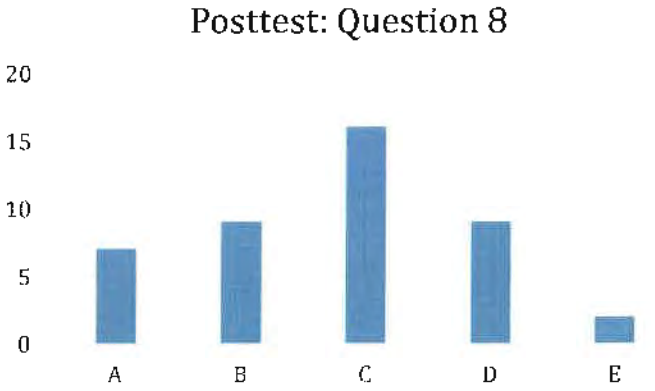
A	7
B	8
C	11
D	7
E	2



Posttest Question 8

Table 8b

A	7
B	9
C	16
D	9
E	2



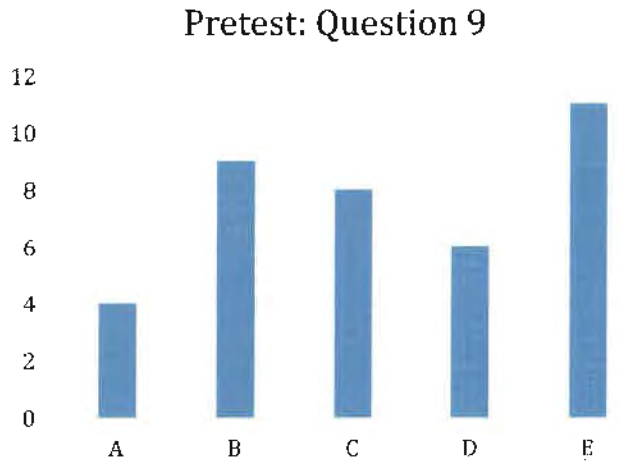
Pretest Question 8 asks, "What are some tough decisions did you or you or do you have to make as a caregiver?" There was a range of participants' responses to the multiple choice answers "a-e" to the question in Table 8a. Seven selected option "a" that they felt alone in the decision making process. Eight selected option "b" for not having the resources to provide the best care. Eleven responded to the question "c" that one of the tough decisions they have to make as a caregiver is deciding what is best for your love one. Seven also selected option "d" that they have no trouble in making decisions in the care of their love one, and two selected for option "e" that the question did not apply to them.

On the other hand Posttest Question 8, Table 8b shows a slight change in response. Seven selected option "a" that they felt alone in the decision making process. Nine selected option "b," for not having the resources to provide the best care. Sixteen responded to the question "c" that one of the tough decisions they have to make as a caregiver is deciding what is best for your love one. Nine likewise selected option "d" that they have no trouble in making decisions in the care of their love one, and two selected for option "e" that the question did not apply to them. Most selected the option that one of the tough decisions they have to make as a caregiver is deciding what is hest for their love one.

Pretest Question 9

Table 9a

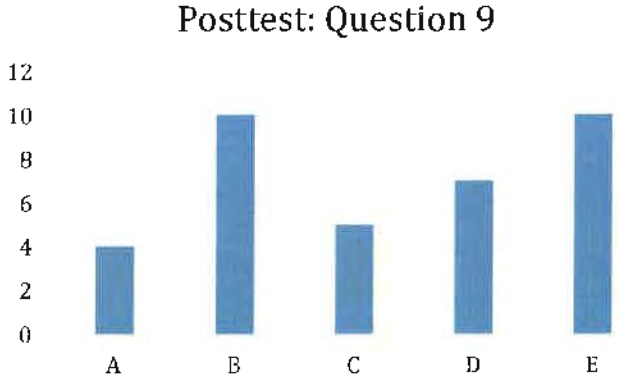
A	4
B	9
C	8
D	6
E	11



Posttest Question 9

Table 9b

A	4
B	10
C	5
D	7
E	10



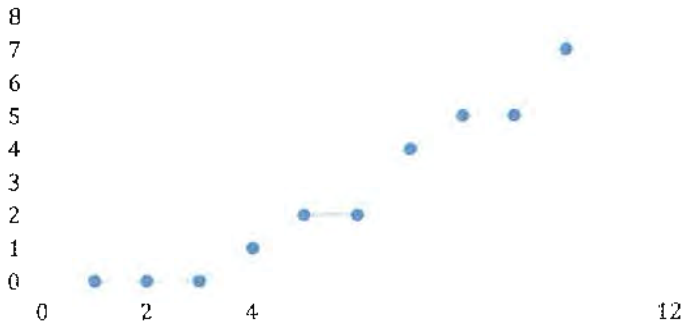
Pretest Question 9 asks, "What are some challenges are you facing now as a caregiver?" It too shows a range of responses to multiple choice answers to the question. Four selected for option "a" that they felt unappreciated. Nine selected option "b" that they were unable to find time for self-care. Eight selected option "c" that they had discomfort about the disease. Six selected option "d" that they felt unhappy with the situation. And eleven selected option "e" that it did not apply to them.

On the other hand Posttest Question 9, Table 9b shows a slight change in the participants' response. It remained the same that four selected option "a" that they felt unappreciated. Ten responded to the question with option "b" that they were unable to find time for self-care. Five selected option "c" that they had discomfort about the disease. Seven selected option "d" that they felt unhappy with the situation. And ten also responded to the question by selecting option "e" that it did not apply to them.

Pretest Question 10

Table 10a

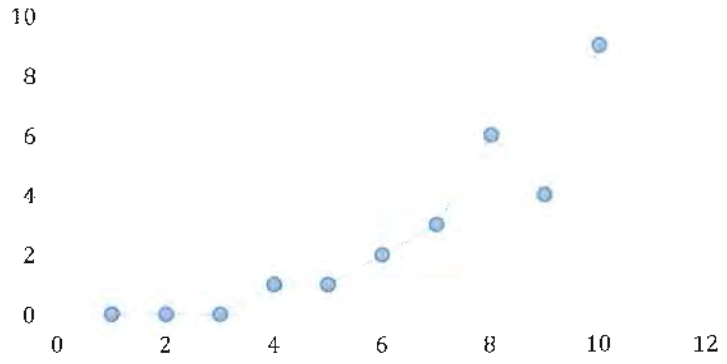
1	0
2	0
3	0
4	1
5	2
6	2
7	4
8	5
9	5
10	7



Posttest Question 10

Table 10b

1	0
2	0
3	0
4	1
5	1
6	2
7	3
8	6
9	4
10	9



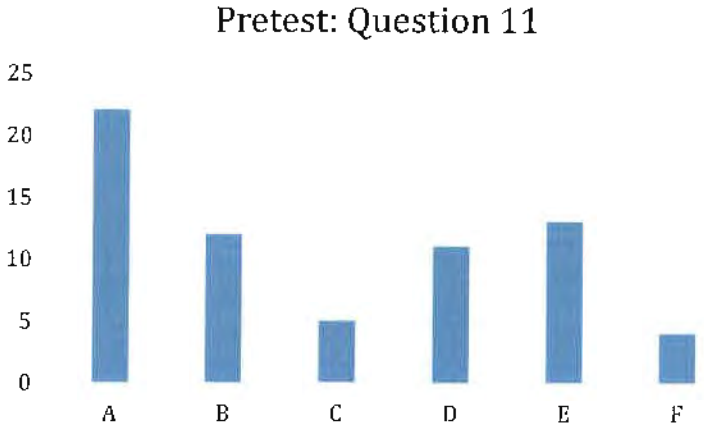
For pretest and posttest Question 10 the line graphs represent the participants' responses to the question of self-care. The question was on a scale of one to ten, with ten being the highest. The question was, "How do you rank your level of self-care?" The pretest X axis is the horizontal numbers on the graph depicting the scale of self-care. The Y axis is the vertical numbers on the graph which depicts the number of people who responded to each number on the scale. Looking at the Pretest graph, more people engaged in some form of self-care. Looking at the Posttest graph there was a change in

the understanding of what self-care is. Four people chose nine on the scale on the Posttest as oppose to five people who chose nine on the Pretest before the presentation.

Pretest Question 11

Table 11a

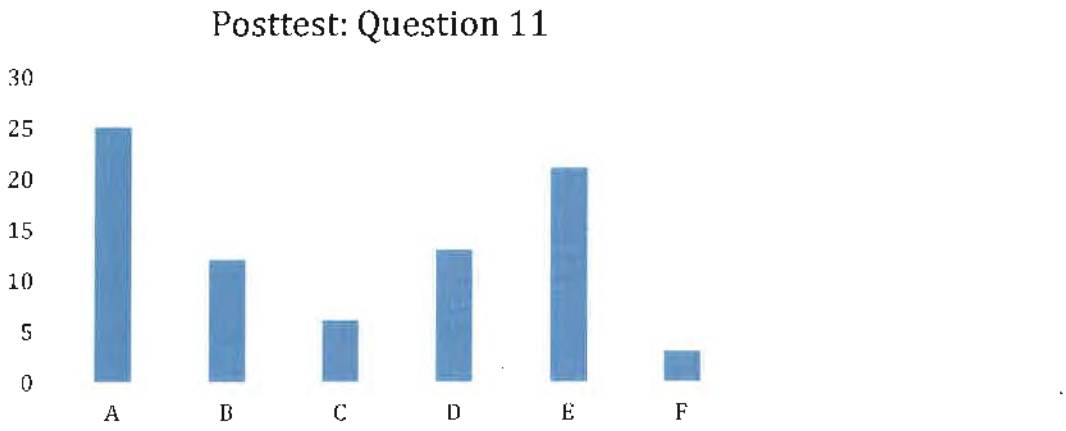
A	22
B	12
C	5
D	11
E	13
F	4



Posttest Question 11

Table 11b

A	25
B	12
C	6
D	13
E	21
F	3



Pretest Question 11, asks, "What do you do to prevent or relieve stress?" which shows a range of responses to the multiple choice question. Twenty-two of the participants selected option "a" that prayer is a stress reliever. Twelve selected option "b" by turning to exercise. Five of the responders selected option "c" says that a drink helps them to relieve stress. Eleven selected option "d" says that sleep helps them to deal with stress. Thirteen selected option "e" that talking to someone helps prevent or relieve stress. And four selected option "e" for "other" which varied in their answers.

However Posttest Question 11, Table 11b shows a complete different range of responses. Again the most, twenty-five of the participants selected option "a" that prayer is a stress reliever. Again twelve selected option "b" by turning to exercise. Six of the

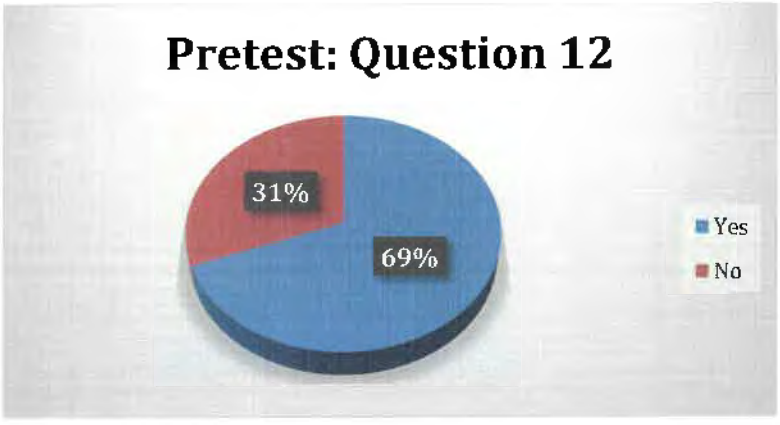
responders selected option "c" says that a drink helps them to relieve stress. Thirteen selected option "d" says that sleep helps them to deal with stress. Even more, twenty-one selected option "e" that talking to someone helps prevent or relieve stress. And three selected option "e" for "other" which varied in their answers.

Prayer outnumbered all responses in both Pretest and Posttest with an increase in the Posttest after the presentation. Prayer provides stress relief in a variety of ways. A prayer for help is a great source of comfort and relief because a person does not feel they have to bear their burden alone. Often when people are hurting or confused, they can feel as if there is no one to talk to or depend on. A prayer during these tense times relieves that feeling of loneliness. The belief that God is listening to their prayers and will help them is a source of hope to many individuals. With hope comes the strength to carry on.

Pretest Question 12

Table 12a

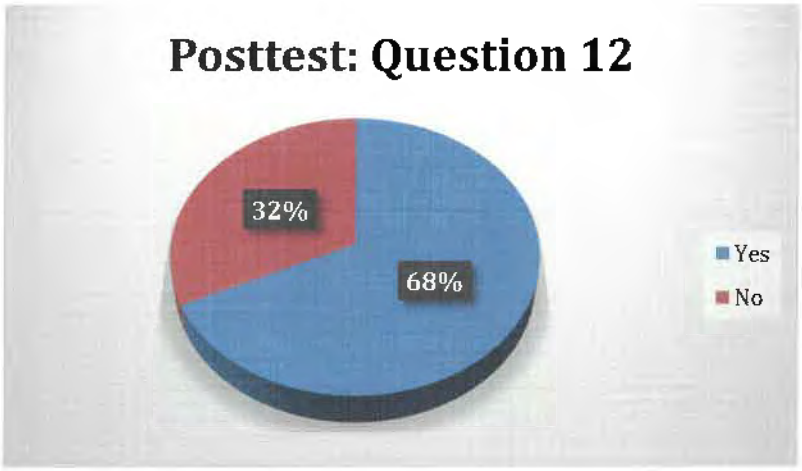
Yes	18
No	8



Posttest Question 12

Table 12b

Yes	17
No	8



The Pretest Question 12 asks, "Would you like to continue to pursue education or training focused on caregiving?" which required a yes or no answer. Sixty-nine percent said "yes" and thirty-two said "no" on the Pretest, whereas sixty-eight percent said "yes" and thirty-two percent said "no" on the Posttest.

What I have learned during this process after having implemented and completed the workshops for this project Bringing Awareness to Faith-based Leaders and Healthcare Professionals on Providing Emotional and Spiritual Support as Caregivers. The presentations were given to the population participants, and the participants completed the pretest and posttest questionnaires related to caregiving. The questions, response options, and graphics gave insight into the pre-established ideas the participants had about caregiving.

The effectiveness of the project was measured by comparing and analyzing the information obtained from the questionnaires, focus groups, and surveys which documented the outcomes of each session. The data was used as an evaluation tool to determine the outcomes of the workshop sessions. New insights and awareness's were gained in doing the research work, and receiving feedback from the participants. The research validates the hypothesis that faith-based leaders and healthcare professionals do need training when it comes to caregiving.

The goal of this project was accomplished by educating and bringing awareness to the participants which consisted of both faith-based leaders and healthcare professionals. They were provided with the "tools" to help increase their self-care and confidence to handle difficult situations, emotions, and decisions when it comes to providing emotional and spiritual support as caregivers.

My future intention for this project is to convert it into an educational tool in the form of a manual. It will be presented to pastors, ministerial alliances, church conferences and conventions, and other faith-based organizations; as well as hospitals, hospices, nursing homes and healthcare institutions.

Summary of Learning

The guidance and support from my mentors in the Focus Group Meetings of each semester has been very helpful. Attending those meetings has greatly assisted me in better preparing myself for my doctoral work. The meetings were very productive in helping me to prepare for my Final Project "Bringing Awareness to Faith-based Leaders

and Healthcare Professionals on Providing Emotional and Spiritual Support as Caregivers."

Having attended the plenaries and listened to the different sermons, especially the one preached by Bishop Peggy A. Johnson. I gained an even better understanding and a greater appreciation for ministry with people with disabilities. Listening to her speak with such transparency, also allowed me to deal with my own disabilities and challenges. It gave me the courage to face some fears that had confronted me since I was a child. After engaging Bishop Johnson in dialogue, I can honestly say that I felt a holistic healing had taken place in my life.

To employ a healthy and holistic outlook on life is essential for all of us. Overcoming fear does not happen instantly or automatically. It is the result of deliberate intention, and conscious action towards doing things that frightens one. As a result of overcoming my fears, I can grow as a person, and expand the possibilities that surround my life. I also learned from Dr. John Swinton that disability is a way of naming things; giving people back their stories. He also stated that disability and the strange new world within the Bible, God chooses disabled bodies to carry out things in the kingdom. I will continue to engage in my theological search that rests on my theological understanding that is informed in my engagement in the peer group sessions and the practice of ministry.

Some questions come to mind as I look at perceptions about my context: How do people perceive and treat individuals with disabilities? Do they treat them with respect or disparagement? What is it like to experience ridicule, shame, disgrace, isolation, and rejection? While not all people do so, some nondisabled people do not empathize with disabled people and the challenges they face. Some feel uncomfortable being a friend to

someone who is perceived differently. People who are not exposed to individuals with disabilities often do not realize that a disabled person, despite his or her disability, is just like a nondisabled person. Everyone should ask themselves, what similarities and differences do I have with people who have disabilities? To what extent do people think individuals with disabilities are different? Nobody should be ostracized for something they have no control over. This is an issue I feel passionate about because I have been a victim of disability discrimination. I have endured many obstacles, but I am now an advocate for disability rights. Everyone should treat disabled individuals with respect, dignity, and concern. People should not assume a disability defines a person's identity.

In fact, people with disabilities can do some things that nondisabled people cannot do, bringing their experience and focus to key aspects of a task. Individuals with disabilities are able to bring work ethic skills to complete an assignment or project, allowing them to make a contribution to society. For some people, having a disability helps them learn to advocate for themselves. Some might say that being nice to people with disabilities is not necessarily treating them the same as the general population as everybody else. However, disabled people want their community to know who they are.

Using an individual's disability to describe who they are is often used in order to describe what they cannot do. One would not go around using race, ethnicity, religion, and gender to describe someone's potential and value, so why use disability in that way. Disability is natural, and it is important to remember that at any moment, someone who may not have one, find themselves with one. No matter what, every single person, at some point in their life, will experience some form of a disability.

I learned that using person first language in everyday life by people with disabilities can help educate others and help change non-disabled people's perceptions, stereotypes, and stigmas towards people with disabilities. While people with disabilities face a lot of challenges in their environment (limited accessibility, and so on), language is a huge barrier that people with disabilities can easily make a difference in everyday situations.

Conclusion

Ministering in a multi-cultural and multi-religious context, I am introduced into encounters with people from all walks of life (ethnicities and religions) in crisis. Out of an intense involvement with people in need, and the feedback from mentor(s) and peers, I am informed with a new awareness of myself as a person and of the needs of those to whom I minister. I am challenge by the plenaries, seminars and peer sessions to think and express myself in new ways theologically about my own faith. I will continue to engage in my theological search that rests on my theological understanding that is informed in my engagement in the peer group sessions and the practice of ministry. Attending Peer group sessions with mentor(s) and interaction with peers greatly assisted me in becoming more alert, observant, and well-rounded as a professional.

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